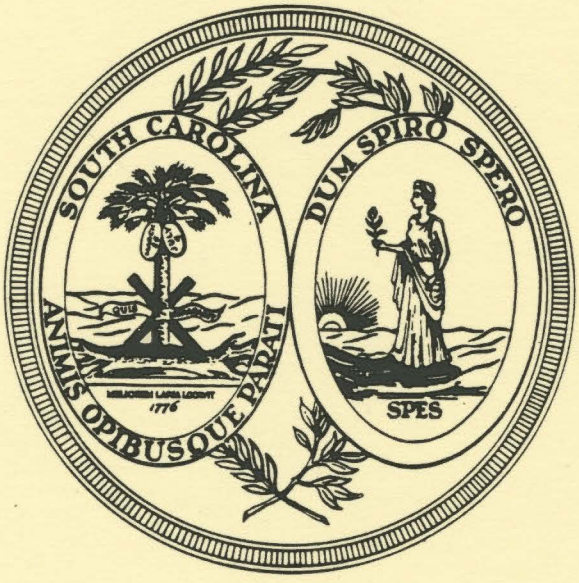
# South Carolina General Assembly




# Legislative Audit Council




**The State of South Carolina**
**General Assembly**
**Legislative Audit Council**
**A Program Review of the**
**South Carolina**
**Workers' Compensation System**
**March 16, 1988**

# THE STATE OF SOUTH CAROLINA

# GENERAL ASSEMBLY

# LEGISLATIVE AUDIT COUNCIL

# A PROGRAM REVIEW OF THE SOUTH CAROLINA

# WORKERS' COMPENSATION SYSTEM

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## INTRODUCTION AND MAJOR FINDINGS

The Legislative Audit Council reviewed the South Carolina workers' compensation program at the request of members of the General Assembly, supported by the Workers' Compensation Commission (see Appendix A). The audit was performed to determine whether the system is equitable, efficient, and effective. The Council issued an audit of the State Workers' Compensation Fund in September 1986 as the first of a two-part review of the program. The present audit focuses on the Workers' Compensation Commission, the agency which administers workers' compensation laws in South Carolina. However, the audit also addresses broader issues relating to the workers' compensation program. This comprehensive review is intended to help fulfill the need for objective information to support an ongoing workers' compensation reform process in South Carolina.

The approach for the Audit Council review was developed from questions that have been raised by Legislators and the public, as well as by researchers who have studied workers' compensation throughout the nation. These questions can be summarized as follows:

1. Are workers' compensation benefits and coverage adequate in South Carolina?

2. Is the delivery of benefits efficient and cost effective; are benefits administered effectively with a minimum of delay and litigation?

3. Are the costs of the system reasonable and are the costs equitably allocated between employers and the consuming public?

### Origin and Nature of Workers' Compensation

Workers' compensation laws are intended to guarantee injured workers compensation for lost wages and medical costs associated with work-related injuries, regardless of who was at fault. Under the previous system of personal injury suits, awards were viewed as inconsistent and legal

costs as high. Court procedures contributed to delays in reaching settlements.

All states enacted workers' compensation laws between 1911 and 1948; South Carolina's law was enacted in 1935. The laws incorporated the principle that industrial accidents were part of the cost of the finished product; compensation for death or injury should be paid by the product consumer without regard to the fault of either employer or employee. Workers' compensation laws were established as the sole remedy, relieving employers from liability in exchange for their becoming responsible for medical costs and lost wages resulting from on-the-job injuries.

## Current Issues in Workers' Compensation

A substantial increase in reported injury rates during the 1960s gave rise to a period of growth in workers' compensation systems. In South Carolina, the number of cases closed in FY 59-60 was 39,356, and by FY 69-70 the number had more than doubled to 80,293. The Occupational Safety and Health Act of 1970 provided for a national commission to study workers' compensation. In response to the 1972 recommendations of the National Commission on State Workmen's Compensation Laws, most states substantially broadened coverage and increased benefits for injured workers.

Additionally, the Council of State Governments published its model workers' compensation legislation in 1974. These suggested laws have been used by various states in developing workers' compensation provisions. National standards are also published by the International Association of Industrial Accident Boards and Commissions (IAIABC). Prototype of an Administrative Workers' Compensation System, a study done for the American Insurance Association in 1982, provides additional recommendations for an effective system. The Audit Council reviewed these

national standards to aid in assessment of the South Carolina program, and refers to them collectively in specific findings in the report.

Cost increases associated with workers' compensation reforms have been substantial. For example, in South Carolina, reforms were one factor which caused the amount of workers' compensation benefits paid to increase more than 600%, from approximately $19.6 million in FY 72-73 to over $144.2 million in FY 85-86. Workers' compensation is in the forefront of state policy debates. The National Conference of State Legislatures reported that 33 of the 49 states holding legislative sessions in 1987 expected workers' compensation to be a major issue.

**Major Recommendations**

The Council found problems with the South Carolina workers' compensation statutes as well as with the administration of the law by the Workers' Compensation Commission. These problems affect both the benefits and costs of the system. There is reduced assurance that the system is equitable to injured workers and employers. The following major recommendations are made to enhance the further review and implementation of the Audit Council report:

1. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THIS REPORT BE GIVEN TO THE SPEAKER OF THE HOUSE AND PRESIDENT OF THE SENATE (LIEUTENANT GOVERNOR) FOR REFERRAL TO THE APPROPRIATE LEGISLATIVE COMMITTEES. THE AUDIT COUNCIL RECOMMENDS THE COMMITTEES CONSIDER RECOMMENDATIONS ADDRESSED TO THE GENERAL ASSEMBLY THROUGHOUT THE REPORT AND ATTEMPT TO DEVELOP A CONSENSUS ON NEEDED REFORM OF THE SOUTH CAROLINA WORKERS' COMPENSATION PROGRAM. REFORM OBJECTIVES SHOULD INCLUDE:

- THE SYSTEM PROVIDES ADEQUATE BENEFITS AT THE LOWEST PRACTICAL COST, AND COSTS ARE EQUITABLY ALLOCATED BETWEEN EMPLOYERS AND THE CONSUMING PUBLIC.

- THE SYSTEM ENCOURAGES REHABILITATION AND DISCOURAGES ABUSE.

- THE SYSTEM INCLUDES THE LARGEST PRACTICAL PORTION OF THE LABOR FORCE AND PROVIDES BENEFITS WITH A MINIMUM OF DELAY AND LITIGATION.

2. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE CHAIRMAN AND THE EXECUTIVE DIRECTOR OF THE WORKERS' COMPENSATION COMMISSION FORM AN ADMINISTRATIVE COMMITTEE CONSISTING OF AT LEAST TWO ADDITIONAL COMMISSIONERS AND TWO REPRESENTATIVES OF COMMISSION STAFF TO CONSIDER THE AUDIT COUNCIL REPORT AND DEVELOP A PLAN TO IMPLEMENT ITS RECOMMENDATIONS. THE COMMITTEE SHOULD PROVIDE A PROGRESS REPORT TO THE GENERAL ASSEMBLY WITHIN ONE YEAR ON THE IMPLEMENTATION PROCESS.

The report contains three parts which address administrative, statutory, and cost issues of the workers' compensation program. It is difficult to isolate problems caused by weaknesses in the law from those caused by the administration of the law. Although findings are grouped according to the major issue needing further review, the report should be considered as a whole in the review process.

Part I of the report addresses administrative issues. The majority of the recommendations in this section are addressed to the Workers' Compensation Commission or its Administrative Committee (see above). Administrative problems identified in the report include:

- South Carolina's Commission system may not be the most effective organization for a workers' compensation administrative agency; other systems have a separate appeals body and a more central administrative authority (see p. 8).

- There are no minimum qualifications for Commissioners, and training has been inadequate to assure the most

efficient and effective resolution of cases (see p. 10).

- Problems with incomplete and inconsistent medical evidence may hinder Commissioners' decision making (see p. 15).

- The Commission has awarded compensation for slight and minor disfigurement, although statutes allow disfigurement benefits only for serious and permanent disfigurement (see p. 18).

- The Commission conducts viewings in uncontested permanent partial disability cases, resulting in benefit delays and increased awards to claimants (see p. 20).

- The Commission has not enforced state regulations and has implemented policy decisions affecting the public without promulgating regulations as required by the Administrative Procedures Act (see p. 31).

- The Commission does not collect statistical data on the amount of claimants' attorneys' fees; an Audit Council review of case records provides information about fees (see p. 35).

- The Commission has not adequately monitored insurance coverage and as a result, cannot ensure that illegally uninsured employers are detected (see p. 49).

- Information management in the agency has been inadequate; the information system does not furnish needed statistical, management, and operating information (see pp. 53, 54, 56).

- The Commission has not enforced laws that assure delays in benefit delivery are minimized (see p. 65).

Part II of the report addresses statutory issues. The majority of the recommendations in this section are addressed to the General Assembly. The statutory issues identified include:

- Statutes do not assure that vocational rehabilitation services will be provided to injured claimants who need them (see p. 82).

- In contrast to other states, the Code of Laws does not make workers' compensation coverage mandatory for all employers; some employees are not eligible for compensation (see p. 85).

- The Code of Laws mandates that a claimant with 50% or more loss of use of the back be considered totally and permanently disabled; persons who may be able to work can unfairly receive total and permanent disability compensation (see p. 87).

- Permanent total disability benefits extend for a maximum of 500 weeks instead of life, which is likely to result in financial hardships for disabled workers (see p. 90).

- Procedures required by the Code of Laws to start and stop disability payments to claimants, who are unable to work because of a job-related injury, are unnecessary and cause delay in the delivery of benefits (see pp. 100, 102).

Part III contains the results of Audit Council investigation of the costs of workers' compensation in South Carolina.

- Although cost comparisons are of limited validity, South Carolina's employer costs have been consistently below both the national and southeastern averages (see p. 111).

- Procedures for determining insurance rates provide the most accurate information about the source of cost variables for workers' compensation insurance; in South Carolina the 4.5% tax and high Second Injury Fund assessment inflate costs for employers and consumers (see pp. 113, 115, 117).

The workers' compensation system is a delicate balance of the interests of employees, employers, and legal and medical professionals. The interdependence of factors in the system should be emphasized. The adoption of each recommendation should be considered in terms of its effect on all the system's connected parts. Balanced reform is necessary to ensure the system is equitable.

# PART I
# ADMINISTRATIVE ISSUES

## Agency Organization

The Workers' Compensation Commission's seven members are appointed by the Governor with the advice and consent of the Senate for terms of six years. The Chairman, designated by the Governor with the advice and consent of the Senate, may serve two nonconsecutive two-year terms in a six-year period. The Chairman is responsible for implementing policies established by the Commission. The Executive Director, who is appointed by the Commission, is responsible for the daily administration of the six departments (see Appendix C).

The Commission made several administrative improvements during the course of the Audit Council review and continued some improvements that had begun prior to the review. For example, corrections were made in procurement procedures and the agency has been certified to make direct agency procurements of goods and services to a limit of $5,000. In FY 86-87, the agency met its Small and Minority Business procurement goals. Additionally, as of September 1986, the Commission ranked 12th out of 72 agencies in reaching its affirmative action employment goals.

The Commission has worked to overcome weaknesses and deficiencies. The past year has focused on basic structural deficiencies. Both the agency's Administrative Policies and Procedures and Operations Policies and Procedures are being systematically reviewed, written, and approved by the Commission. In addition, the agency has updated position descriptions for all employees and has begun to institute the Employee Performance Management System (EPMS) for all applicable employees. With a more solid infrastructure, the Commission can address more substantive and programmatic issues.

However, South Carolina's Commissioner system deviates from agency structure in other states and from recommended workers' compensation organizational structures. Additionally, there are no minimum professional requirements for Commissioners. These and other issues are discussed in the following pages.

## South Carolina's Commission System

South Carolina's Commission system differs in two ways from agency structures in other states and from recommended organizational structures: (1) Commissioners hear all contested cases, and appeals of individual Commissioner's decisions. (2) South Carolina statutes do not provide for a single administrative director to be responsible for daily operations, and individual Commissioners are not under the central authority of the Chairman or a majority vote of the Commission.

### (1) Judicial Organization

South Carolina Commissioners function as administrative law judges. However, they hear and determine all contested cases and also review appealed decisions issued by their peers (see p. 95). Other states separate the responsibility of hearing contested cases at the first level from the body that reviews appealed decisions. Virginia, North Carolina, Georgia, and Mississippi each has a three-member Commission, with members who are gubernatorial/legislative appointees, that hears appeals. Each of these states employs attorneys as hearing officers to preside over disputed cases at the first level. As of 1985, at least 18 other states employed hearing officers.

National standards recommend a separate three-member appellate body. Standards advocate using hearing officers to preside over contested cases at the first level and that they be attorneys. Additionally, experience and continuity

are considered essential to the proper administration of a workers' compensation act.

Commissioners in South Carolina make decisions on contested cases at the first level, and are gubernatorial appointees, with no guarantee of reappointment. Six new Commissioners were appointed during FY 84-85 and FY 85-86. Additionally, beginning in August 1987, the Commission was without a member to hear contested cases because the Senate was not in session to confirm an appointment to a Commission vacancy. Also, in South Carolina there are no minimum qualifications for Commissioners (see p. 10).

The Commission is a quasi-judicial body, yet its appeal system is peer review rather than review by a separate appellate body. This system provides less assurance of an independent review process and may appear to provide opportunity for biased decision making.

**(2) Administrative Organization**

The Full Commission establishes administrative policies and procedures and the Chairman is responsible for their execution. However, statutes do not provide for a single administrative head of the agency to be responsible for day-to-day operations, and individual Commissioners are not bound by the authority of the Chairman or a majority vote of the Commission.

In Virginia, North Carolina, Georgia, and Mississippi, the three-member Commission is responsible for administrative oversight of the agency. Hearing officers in these states report to their Commission or Chairman. Also, two of these states have a Director responsible for agency operations, and a third is reorganizing to employ a single Director.

National standards advocate the employment of a single Director to be responsible for day-to-day operations and that only the Chairman of the Commission have authority over hearing officers or other personnel.

A lack of a central authority has produced inconsistencies between Commissioners which could undermine the agency's effectiveness. For example, one Commissioner has continued to conduct informal conferences to determine claimants' permanent partial disability, while others have allowed a Deputy Commissioner to sit in their place. Commissioners may also be inconsistent in their approval of attorney fees. The absence of a higher authority has allowed a Commissioner to refuse to hear cases of certain attorneys, resulting in the remaining Commissioners having to assume responsibility for conducting these hearings.

The number of Commissioners has grown from 5 in 1935 to 7 in 1978. However, adding more Commissioners to accommodate an increasing volume of cases would further decentralize authority and decrease efficiency and cost effectiveness.

**RECOMMENDATION**

3. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER REVIEWING ALTERNATIVES TO CURRENT WORKERS' COMPENSATION ORGANIZATIONAL STRUCTURE. THE WORKERS' COMPENSATION COMMISSION'S ADMINISTRATIVE COMMITTEE'S RECOMMENDATIONS SHOULD ALSO BE CONSIDERED IN EVALUATION OF THESE ISSUES.

**Professional Requirements for Commissioners**

The South Carolina Workers' Compensation Commission has not established a formal training program for Commissioners. Also, §42-3-20 of the South Carolina Code of Laws does not specify minimum qualifications for Workers' Compensation Commissioners.

**No Formal Commissioner Training Program**

New Commissioners are not formally oriented to the law, policies, or forms used in the South Carolina system. Also, the Commission has not implemented a formal continuing education program for Commissioners in areas related to judicial decision making and the evaluation and use of medical evidence (see p. 15). Six of the seven Commissioners serving in FY 86-87 stated there were problems with Commissioner training even though some received assistance from past Commissioners.

In 1985, the Commission enrolled two Commissioners in a workers' compensation course sponsored by the International Association of Industrial Accident Boards and Commissions (IAIABC). In addition, during the Council's review, the Commission held a continuing education seminar and the Commissioners attended a medical seminar sponsored by an area hospital.

Florida and Virginia have formal training programs in which a new hearing officer observes the proceedings of an experienced hearing officer. Mississippi Commissioners participate in national training programs such as those sponsored by the IAIABC and the National Judicial College. Additionally, workers' compensation hearing officers in Georgia, Mississippi, and Virginia, who are required to be attorneys, are required to obtain continuing legal education annually. In Florida, annual legal training will be mandatory by January 1988.

**No Minimum Qualifications Required**

Commissioners function as administrative law judges but are not required to have minimum professional qualifications. Section 42-3-20 states:

> The commissioners shall hear and determine all contested cases, conduct informal conferences...approve settlements, hear applications for ...reviews, and handle such other

> matters as may come before the department for judicial disposition....

The Executive Director estimated that 99% of a Commissioner's time is spent on adjudication of claims. This includes presiding over hearings, taking evidence, interpreting the workers' compensation laws, and writing decisions and orders. Commissioners who do not have legal training may not be familiar with accepted procedures for analyzing evidence presented in cases. However, Commissioners, solely, determine settlements in contested cases, without the benefit of a jury.

Between July 1986 and July 1987, three of the seven Workers' Compensation Commissioners were attorneys. But Commissioners have been appointed who had no prior experience in workers' compensation and no legal training. For example, Commission appointees have included a public school administrator and a marketing manager.

Workers' compensation agencies in North Carolina, Georgia, Florida, Mississippi, and Virginia require hearing officers to be attorneys with three to five years experience and membership in the state bar association. In Alabama and Tennessee, workers' compensation cases are administered by judges through the court system.

The Council of State Governments recommends that workers' compensation hearing officers be licensed attorneys. The National Institute on Rehabilitation and Workmen's Compensation recommends that administrators of workers' compensation should be hired based only on their technical and professional qualifications.

**Conclusion**

The State has a responsibility to assure that Workers' Compensation Commissioners have minimum qualifications and are adequately oriented to the system. Without this assurance, claimants and employers could have fewer

guarantees that benefits are administered and claims adjudicated in an efficient and effective manner.

**RECOMMENDATIONS**

4. THE WORKERS' COMPENSATION COMMISSION SHOULD ESTABLISH AND IMPLEMENT A FORMAL TRAINING PROGRAM FOR COMMISSIONERS. THIS PROGRAM SHOULD PROVIDE FOR COMPREHENSIVE ORIENTATION FOR NEW COMMISSIONERS AS WELL AS CONTINUING EDUCATION TRAINING FOR ALL COMMISSIONERS.

5. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER WHETHER §42-3-20 OF THE SOUTH CAROLINA CODE OF LAWS SHOULD BE AMENDED TO REQUIRE COMMISSIONERS TO MEET MINIMUM PROFESSIONAL QUALIFICATIONS.

**Statutory Organizational Requirements**

Statutes specifying responsibilities of the Judicial and Administrative Department heads are unnecessary and restrict the Commission from legally altering duties or implementing needed organizational changes. Further, the structure of the Administrative Department cannot legally be altered by the Commission.

Section 42-3-25 of the South Carolina Code of Laws states that the Commission shall have an Administrative Department and a Judicial Department. Sections 42-3-50 and 42-3-80 specify the job functions for the two department heads in detail usually found in Human Resource Management's class specifications.

In order to increase operating efficiency, the Commission has found it necessary to alter its organizational structure. Section 42-3-90 states three

divisions shall be established within the Administrative Department: (1) Coverage and Compliance, (2) Claims and Statistics, and (3) Medical Services. However, the Claims, and Coverage and Compliance Divisions have each been set up as separate departments, while the Medical Division has been placed in the Claims Department. An Information Resource Management Department has been established to assist in managing the agency's computerized information system, and a Legal Department to assist the Commission in legal matters.

Additionally, reporting lines have been changed. The Judicial Director no longer reports directly to the Chairman, but does so through the Administrative Director, now named the "Executive Director."

The law does not allow the Commission flexibility to make organizational changes that may be necessary without going through the legislative process to amend statutes. To function effectively, it is essential that organizations be able to plan for and adapt to change, and have the ability to arrange their structure and resources to optimize efficiency and effectiveness. Additionally, nationally developed model legislation states the agency should be able to establish such divisions and sections as necessary to administer the act.

**RECOMMENDATION**

6. THE WORKERS' COMPENSATION COMMISSION'S ADMINISTRATIVE COMMITTEE SHOULD RECOMMEND NEEDED STATUTORY CHANGES REGARDING ORGANIZATION TO THE GENERAL ASSEMBLY TO INCLUDE POSSIBLE DELETION OF §42-3-50, §42-3-80, AND §42-3-90 OF THE SOUTH CAROLINA CODE OF LAWS.

## Awarding of Claims

Questions have been raised regarding Commissioners' use of discretion in awarding benefits to claimants whose accidents and/or injuries are questioned by their employers. Commissioners act as administrative law judges and must weigh conflicting evidence and determine the facts in light of the law's requirements; their decisions involve the application of judgment and discretion in evaluating the law and evidence of the case.

Liability and disability questions that are adjudicated by Commissioners are by nature subjective. However, in this section, the Audit Council has recommended measures that place limits on discretion and may lead to greater consistency.

### Medical Evidence

Commissioners decide cases and make permanent disability awards to claimants based, in part, on medical evidence submitted by physicians. However, the Commission has not required evidence to be uniform or detailed. Incomplete and inconsistent medical evidence may hinder the prompt and equitable resolution of cases.

Commissioners use medical evidence to determine the cause and extent of an injured worker's disability. A claimant with permanent impairment is examined by one or more physicians who evaluate his impairment and express it numerically as a percentage of the affected body part. The Commission's medical report form asks physicians whether the claimant has any permanent injury and, if so, that it be described fully, but the space provided for this information is not adequate. Physicians often submit narrative reports, but the Commission does not require them.

Section 42-1-120 of the South Carolina Code of Laws defines disability as the "employee's incapacity to earn the wages he was receiving at the time of injury."

Commissioners use the medical evidence of physical impairment ratings in consideration with other factors, such as age, occupation, education, and skills, to produce disability ratings, their estimate of the claimant's loss of ability to "engage in gainful activity." For example, an accountant who lost a leg would suffer less disability than a construction worker with the same injury.

In order for the Commission to make accurate disability awards, medical evidence should be specific and detailed. One Commissioner estimated that the medical documentation in reports is inadequate 25% of the time. For example, medical reports do not always mention whether, or in what way, the physician used one of the standard guides to physical impairment, or whether factors such as pain and physical limitations were considered. A Commissioner stated the claimant's prognosis, or prospects of developing future problems because of the injury, is necessary evidence that is often omitted.

The existence of conflicting medical opinions in many cases may add to the problems caused by inadequate medical evidence. In an Audit Council sample of 82 contested cases scheduled for hearings in FY 85-86 in which compensation was awarded for back injuries, 31 (38%) of the cases had two or more impairment ratings. For some, a divergence existed between the ratings of treating physicians, employed and selected by the employers/carriers (see p. 92), and those of physicians employed by the claimant. For example, in one case the treating physician reported a 20% disability to the spine (60 weeks of compensation), and the claimant-chosen physician rated the disability at 50% (500 weeks of compensation, see p. 87). A majority of the Commissioners stated that most reports are influenced by which party has employed the physician. They consider their past experience with the physician and his reputation in evaluating his numerical ratings.

When contested cases are settled by clincher agreements or compromise settlements (see p. 26), the written agreement usually does not specify an agreed-upon numerical disability rating, and sometimes the files for cases settled by clinchers do not contain any medical evidence. Because 80% of the cases in the Audit Council sample of contested back cases were settled by clinchers, statistical data to quantify the relationship of final settlement ratings to physicians' ratings supplied by claimants and defense could not be developed. However, in a sample of uncontested permanent partial disability cases, Commissioners' disability ratings were greater than physicians' impairment ratings by an average of 34% (see p. 20).

There is no generally accepted method for transforming symptoms into numerical impairment ratings. Impairment rating has been characterized by one researcher to be "as much art as science." However, there are standard guides for the measurement of impairment, such as those developed by the American Medical Association and the American Academy of Orthopedic Surgeons, that are required by some states. Other states, such as Minnesota, have their own guidelines. No single guide is considered to be authoritative, and the way a guide is used cannot be standardized or controlled.

One method of standardizing the medical information supplied by the physician is the use of a standard form for all permanent impairment ratings. Mississippi, Florida, and North Carolina require these forms and the South Carolina Commission, during the course of the audit, has discussed and drafted such a form.

Medical evidence that is presented in a consistent format can assist Commissioners in decision making. Problems with medical evidence can cause added expense and delays when claimants must be evaluated several times before a decision can be reached.

**RECOMMENDATION**

7. THE WORKERS' COMPENSATION COMMISSION, IN CONSULTATION WITH MEMBERS OF THE MEDICAL PROFESSION, SHOULD DEVELOP AND REQUIRE THE USE OF A STANDARD FORM FOR THE REPORTING OF PERMANENT IMPAIRMENT RATINGS. THE FORM SHOULD REQUIRE DETAILED AND QUANTITATIVE INFORMATION ON ALL FACTORS AND GUIDES USED TO DETERMINE THE NUMERICAL IMPAIRMENT RATING.

**Disfigurement**

Contrary to state law, which provides benefits for serious and permanent disfigurement, the Workers' Compensation Commission has awarded compensation for slight and minor disfigurement. Additionally, the Commission has not awarded compensation based on its own definition of "disfigurement."

The Commission has defined disfigurement based on state law and a South Carolina Supreme Court decision. According to a Claims Division document, a permanent or serious disfigurement is scarring, visible from eight feet away, to any part of the body normally exposed in employment, including serious burn or keloid scars on any part of the body. A viewing or informal conference is held to allow a Commission official (Commissioner or Deputy Commissioner), to look at the disfigurement and assess its severity.

Section 42-9-30 (21) of the South Carolina Code of Laws states:

> Proper and equitable benefits shall be paid for serious permanent disfigurements of the face, head, neck or other area normally exposed in employment, not to exceed fifty weeks... disfigurement shall also include compensation for burn scars or keloid scars....

South Carolina Regulation 67-33 reiterates this statute.

According to Commission records, disfigurement cases from November 1985 to October 1986 accounted for awards of $1.8 million. Approximately 66% of these cases (1,200 of 1,829) involved average compensation awards of $480 (five or fewer weeks), and accounted for almost one-third of the total $1.8 million awarded for disfigurement.

State officials in Alabama, Tennessee, and Virginia told the Council they have few disfigurement cases. A claims examiner in Virginia estimated that it receives approximately 12 disfigurement claims per month. However, South Carolina from November 1985 to October 1986 averaged 152 disfigurement claims per month.

Georgia does not provide disfigurement benefits. Further, disfigurement in Alabama and Tennessee must be shown to affect a worker's employability in order to be compensable.

The following are examples of disfigurement cases where the Commission defined scars as being "...serious permanent disfigurements...normally exposed in employment...":

- An employee was scratched on the forearm by a patient at work. During the viewing of this employee's scar, a Commission official commented that a microscope might be needed to see this scar. The claimant received one week of compensation ($202).

- Two employees working for the same employer were injured. One employee received a second degree burn on his right forearm; the other received a second degree burn on his left forearm. Both employees received treatment on the job and lost no time from work. These injuries were described on the award form as "1 spot." The two employees received $113 and $115, respectively.

- An employee was seeking compensation for scarring on his left and right arms, left index finger, right knee, and right eyebrow. A Commission official, who viewed the scarring from approximately one foot away, ruled that this claimant receive a total of five weeks of compensation. This claimant received $1,475 in compensation.

- A policeman was bitten on the leg by a dog while making an arrest. The Commissioner viewing the case commented that the claimant had two little scars. Since these

scars were on this claimant's leg, they would not normally be exposed in his employment as required by the statute. This claimant received $269.

Awarding benefits for minor disfigurement leads to higher insurance rates, which is costly to employers and consumers. When claimants receive compensation for minor disfigurement, other employees are likely to seek such compensation.

**RECOMMENDATION**

8. THE WORKERS' COMPENSATION COMMISSION, IN ACCORDANCE WITH STATE LAW, SHOULD AWARD COMPENSATION ONLY FOR DISFIGUREMENT OF A SERIOUS AND PERMANENT NATURE NORMALLY EXPOSED IN EMPLOYMENT.

9. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER WHETHER CLARIFICATION IS NEEDED IN THE STATUTORY DEFINITION OF DISFIGUREMENT.

**Uncontested Permanent Partial Claims**

The Workers' Compensation Commission conducts conferences in uncontested cases of permanent partial disability (PPD), which contributes to delays in claim payments and increased awards. Between November 1985 and November 1986, the Commissioners spent approximately 44 days conducting over 2,600 conferences to determine awards. Other southeastern states award benefits in cases of this type without holding conferences.

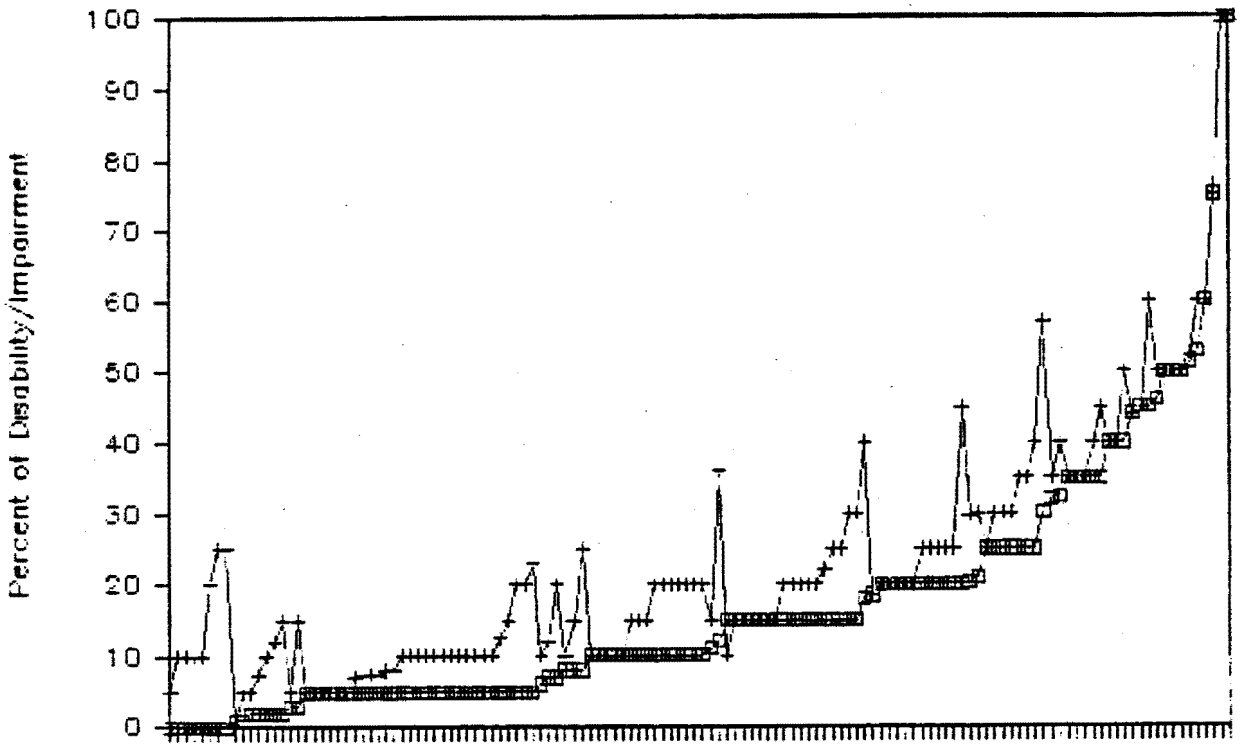
Permanent partial disability occurs when an injury or illness results in the complete loss of, or a permanent impairment to, a part of the body. When the patient has reached maximum medical improvement, the physician gives an impairment rating. Then a conference ("viewing") is attended by the claimant, a representative of the insurance

company and/or employer, and a Commissioner. The Commissioner gives the claimant an industrial disability rating, which may differ from the physician's impairment rating, and is used to calculate the amount of compensation paid.

The Audit Council sampled 132 uncontested cases from November 1985 to November 1986. Figure 1 plots physicians' and Commissioners' ratings for each of these cases.

**FIGURE 1**

**PHYSICIAN/COMMISSIONER RATINGS**




132 Sample Cases

☐ Physician's Rating + Commissioner's Rating

Source: Audit Council Research.

Commissioners' overall average disability ratings were 34% higher than the physician's physical impairment rating. In 70% of the cases reviewed the Commissioner's rating was higher than the physician's. The sample indicates the average amount of compensation paid per case is relatively small, less than $5,000. The award was less than this amount in 65% of the sampled cases. In addition, according to Commissioners, a majority of these claimants do return to their previous employment.

As noted (see p. 15), Commissioners state they consider who has employed a physician, the employer or claimant, in evaluating the physician's impairment rating. Currently, impairment ratings are usually made by the treating physician, chosen by the employer in South Carolina. If the PPD award in these uncontested cases is based on a medical rating, the claimant should have a choice in selecting his/her treating physician (see p. 92).

Section 42-3-20 of the South Carolina Code of Laws states Commissioners must "approve settlements." The Commission interprets the approval requirement to mean that the claimant must be "viewed" in order for a disability rating to be given; however, this is not stated in statute. Seven of eight southeastern states contacted by the Audit Council do not hold conferences for uncontested claims; the physician's impairment rating is used to calculate the compensation amount and claims approvals are handled without holding a conference. If South Carolina based awards on the physicians' impairment ratings, the total payment amount for claims in this category could be reduced, and some of these funds could be reallocated by carriers and employers within the workers' compensation system.

Handling the approval of these uncontested claims without holding a conference would also result in more timely payments to the injured employee. The sample shows an average delay of six months from the date of the physician's rating until the conference was held. Four

states which do not hold conferences estimated that payments to claimants are made within a month after the physician's impairment rating is given.

The Commission should schedule a conference for disputed claims or in special cases (back injury, amputation, etc.) where the Commission determines a conference to be necessary. This would allow a reallocation of the time currently spent by Commission staff and others to conduct and attend the conferences.

**RECOMMENDATION**

10. IF THE GENERAL ASSEMBLY AMENDS STATUTES TO ALLOW CLAIMANTS TO CHOOSE THEIR OWN PHYSICIANS (SEE RECOMMENDATION 73), THE WORKERS' COMPENSATION COMMISSION SHOULD CONSIDER HANDLING AND APPROVING UNCONTESTED PERMANENT PARTIAL CLAIMS WITHOUT HOLDING CONFERENCES.

11. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER REVIEWING STATUTORY PROVISIONS CONCERNING THE WORKERS' COMPENSATION COMMISSION'S APPROVAL OF SETTLEMENTS.

**Decision Manual**

The Workers' Compensation Commission does not maintain a decision manual containing summaries of appealed workers' compensation cases. There is no systematic way for Commissioners, claimants, or attorneys to find decisions relating to a particular subject or issue. This can result in inconsistent handling of contested claims and inequitable treatment of claimants.

Without the aid of a decision manual, in FY 84-85 and FY 85-86, the Commission held 1,639 and 1,774 hearings and awarded total compensation in the amounts of $68 million and

$96 million, respectively. Additionally, 386 and 440 cases were appealed in the two fiscal years.

In the adjudicative process, it is necessary that Commissioners know what previous decisions may be applicable or pertinent. A decision manual referenced by subject matter would allow Commissioners to examine cases occurring before and during their term. Also, because such a manual would outline criteria and issues used in deciding workers' compensation cases, it could serve as a training tool for new Commissioners who in many instances have no legal background (see p. 10). In FY 84-85 and FY 85-86, six of the seven Commissioners were new and did not have easy reference to Commission precedents.

The Employees' Compensation Appeals Board of the United States Department of Labor annually publishes its cases including summaries of the accidents, evidence presented, and the Board's decisions. This publication allows examination of criteria used to decide workers' compensation cases.

**RECOMMENDATION**

12. THE WORKERS' COMPENSATION COMMISSION SHOULD IMMEDIATELY BEGIN DEVELOPMENT OF A DECISION MANUAL WHICH INDEXES APPEALED WORKERS' COMPENSATION CASES, CROSS-REFERENCING THE INFORMATION BY SUBJECT MATTER OR MAJOR ISSUES. THE LEGAL STAFF OF THE WORKERS' COMPENSATION COMMISSION SHOULD MAINTAIN AND KEEP THE MANUAL CURRENT.

**Lump Sum Settlements**

The Workers' Compensation Commission approves the distribution of large sums of cash to claimants. The objective of workers' compensation benefits is to replace lost wages and provide economic benefits to the claimant

over a period of time. However, according to language found in §42-9-301 of the South Carolina Code of Laws, the Commission can award these periodic (weekly) payments in a lump sum if it "...deems it not contrary to the best interests of the employee or his dependents." The Commission has not promulgated regulations to clearly define this section.

Lump sum awards are frequently used to pay permanent disability awards made by the Commission. Agency policy does not require Commission approval for lump sum awards of 100 weeks or less for permanent disability cases. Requests for lump sum awards for large income benefits must be approved by, and are sometimes ordered by, the Commission. Additionally, clincher agreements (compromise and release settlements) are awarded in a lump sum. However, clincher agreements not only release the employer from liability for future income benefits, but also for liability for any future medical benefits (see p. 26).

Because the Commission does not maintain adequate information (see p. 54), the Audit Council was not able to determine how many lump sum payments are awarded annually. However, according to a Commission official, applications for lump sum payments are rarely denied.

The standard given by the statute, "in the best interest of the claimant," offers little firm guidance and control for the Commission in administering lump sum awards. The Commission has not promulgated regulations defining what is in the best interest of the claimant.

Arthur Larsen, a noted authority on workers' compensation, states one reason for the excessive and indiscriminate use of lump sum awards in workers' compensation is that a single resolution of the case provides incentives for all parties. However, according to Larsen, the purpose of periodic income benefits is to provide ongoing support to a disabled worker. It is difficult to determine whether the claimant's current

hardship request is valid when compared with the hardship he may face later if his lump sum award is spent and he is left without ongoing support.

Nationally developed model legislation restricts lump sum awards to those exceptional cases which would be in the best interests of the rehabilitation of the worker. Thus, lump sum awards would pay legitimate educational, retraining, and rehabilitative costs to help return the claimant to gainful employment.

A study for the American Insurance Association also recommends limiting the use of lump sum awards to returning employees to gainful employment. The study states lump sum proceeds could, for example, aid in rehabilitating an employee through the purchase of a business for which he/she is trained and has a reasonable expectation of being successful.

**RECOMMENDATION**

13. THE WORKERS' COMPENSATION COMMISSION SHOULD PROMULGATE REGULATIONS FOR THE APPROVAL OF LUMP SUM AWARDS. REGULATIONS SHOULD DEFINE HOW TO DETERMINE THE "BEST INTERESTS OF THE EMPLOYEE OR HIS DEPENDENTS," AS STATED IN §42-9-301 OF THE SOUTH CAROLINA CODE OF LAWS.

**Clincher Agreements**

The Workers' Compensation Commission approves compromise and release (clincher) settlements. A clincher agreement requires the insurer to pay the claimant a lump sum in exchange for a release from all future income and medical liability. Clincher agreements have all the disadvantages of a lump sum settlement (see p. 24); however, a clincher agreement also releases the insurer from liability for the claimant's medical needs from the point of

the agreement on. This means the claimant is responsible for any medical expenses from that day forward if the injury requires more treatment.

Of cases closed in calendar year 1986 in which income benefits were paid, approximately 4,200 (25%) were settled by clinchers. The Audit Council could not make comparisons of this data with other states since data elements collected vary and are not standard.

According to national standards, clincher settlements may not be in the best interest of the claimant since they are often made for serious injuries whose medical needs are difficult to estimate before treatment is complete. If the injury requires more treatment than was originally estimated, the claimant would have to be responsible for the medical care.

For example, according to the Workers' Compensation Research Institute, a back injury is one in which the extent of impairment is often difficult to measure. In South Carolina, of 5,182 cases in which hearings were requested during FY 85-86, 1,191 (23%) were back cases. An Audit Council sample of 82 of these contested back cases indicated that 66 (80%) were settled by clincher agreements, releasing the employer of liability for future medical benefits.

The liability of an employer for future medical benefits is limited in cases of permanent partial disability. In these cases, the claimant with a clincher settlement waives his rights to future medical benefits if his condition should get worse within a year after the case was settled. In a permanent total disability case, the claimant with a clincher settlement waives his right to receive the lifetime medical benefits for his injury specified by §42-3-30 of the South Carolina Code of Laws.

The national standards recommend that the workers' compensation agency be particularly reluctant to permit agreements which terminate medical benefits. Also,

nationally developed model legislation does not allow future medical benefits to be paid as lump sum awards.

Section 42-3-20 gives the Commission authority to approve settlements. Commission officials stated that approval for clincher agreements is granted on a case-by-case basis. They state no standard criteria for approval can be applied to each case. Clincher agreements terminate potential financial liability and administrative responsibility for the employer or the insurance carrier and reduce the administrative load of the agency. However, according to the National Commission on State Workmen's Compensation Laws, these factors do not provide adequate justification for a procedure which can seriously deprive the employee of his rights.

**RECOMMENDATION**

14. THE WORKERS' COMPENSATION COMMISSION SHOULD PROMULGATE REGULATIONS TO ASSURE THE CAREFUL REVIEW OF CLINCHER AGREEMENTS, INCLUDING DOCUMENTATION THAT CLAIMANTS' NEEDS FOR FUTURE MEDICAL CARE ARE CONSIDERED.

**Use of Medical Experts**

The Workers' Compensation Commission has not used medical expert panels as provided by §42-11-130 of the South Carolina Code of Laws to determine complex medical questions in occupational disease. Instead, the Commission has chosen to follow exclusively another section of the statutes which allows referral of cases to a single physician. From 1983 to January 1987, awards in closed cases amounted to almost $5 million in medical and compensation benefits. Because occupational disease claims involve complex medical issues, many cases are contested and require the evaluation of specialized technical evidence. Fair, cost-effective, and consistent resolution of these cases may require review by a

group of physicians with clinical expertise to judge the cause, diagnosis, and extent of impairment.

The South Carolina Code of Laws provides for the establishment of three-member medical boards for use in occupational disease cases. Section 42-11-170 requires a list of candidates for the medical advisory panel is provided to the Workers' Compensation Commission by the South Carolina Medical Association. After review, candidates' names are forwarded to the Governor's Office. Members of the boards then are to be drawn from a medical advisory panel appointed by the Governor for two-year terms. They are to be compensated by the Commission only for the time served on medical boards in specific cases. Medical decisions are considered binding unless, after written objection, they are proven erroneous. The Commission on June 29, 1987 transmitted to the Governor's Office as required a list of recommendations for appointment to the medical panel. However, as of January 1988, no medical advisory panel was constituted and operating.

Legislation providing for the use of panels was enacted in 1949 but was seldom used until the mid-1970s with the increase in claims for byssinosis. However, research by the Workers' Compensation Research Institute (WCRI) reports that members of the South Carolina Commission and claimant's attorneys were not pleased with the boards in that they felt constrained by the binding nature of the decisions. Additionally, funding was a problem in that the Commission had to pay some costs. Also, the qualifications of the panel were questioned. Some felt they lacked the expertise to evaluate byssinosis cases.

It has been the Commission's practice since 1978, as allowed by §42-11-185, to refer disputed cases to a doctor specializing in occupational diseases employed at one of the state's medical schools, instead of using medical panels. Fees are paid by a special agency fund, unless the claimant

wins, in which case the losing party pays fees. The physicians' decisions are advisory.

National standards recommend the cause of a disease be determined by a disability evaluation unit under the control and supervision of the workmen's compensation agency. Research by the Workers' Compensation Research Institute (WCRI) shows that although some panels are limited to specific occupational diseases, there are some states that authorize their panels to hear all types of disease claims. Others authorize panels to hear injury cases as well.

Of 14 states analyzed by the WCRI, seven had abandoned or rarely used their panels. There are certain features, however, that are thought to contribute to the success or failure of the panel system:

1. Highly qualified, well-respected, and objective physicians should be appointed through a nonpolitical process. Their compensation must be adequate.

2. Panel findings should be advisory in order to promote the more frequent use of the panels and the more frequent acceptance of their opinions.

3. Panels should examine and issue medical judgments, not adjudicate.

South Carolina's appointment and use of medical experts under §42-11-130 meets the above criteria with one exception; decisions are binding. Additionally, South Carolina statutes could be confusing in that they contain three sections which all refer to the use of medical experts. Section 42-17-30 provides for the appointment of a physician to examine injured employees. This section does not require the physician be selected from an approved list. As discussed, §42-11-130 and §42-11-185 both provide for appointment of medical experts. Consolidation of these sections could provide for clearer interpretation of the law and more consistent use of medical experts.

**RECOMMENDATIONS**

15. THE WORKERS' COMPENSATION COMMISSION SHOULD PROMULGATE REGULATIONS THAT ESTABLISH CRITERIA FOR THE USE OF MEDICAL BOARDS IN COMPLEX CASES.

16. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER WHETHER §42-11-160 OF THE SOUTH CAROLINA CODE OF LAWS SHOULD BE AMENDED TO DESIGNATE DECISIONS ON QUESTIONS BY THE MEDICAL BOARDS AS ADVISORY.

17. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER WHETHER §42-17-30, §42-11-130, AND §42-11-185 SHOULD BE CONSOLIDATED IN ORDER TO PROVIDE FOR MORE CLEAR INTERPRETATION OF THE LAW AND MORE CONSISTENT USE OF MEDICAL EXPERTS.

**Workers' Compensation Regulations**

The Workers' Compensation Commission has not enforced rules and regulations that implement the Workers' Compensation Act. Also, the Commission has instituted policy changes without statutory authority rather than amend regulations as outlined in the Administrative Procedures Act (APA) (§1-23-10 to §1-23-160 of the South Carolina Code of Laws).

**Commission Enforcement**

The Audit Council reviewed compliance with some regulations that affect the processing of claims and, therefore, the timely award and payment of benefits. The following are instances of noncompliance:

1. In violation of Regulation 67-6, the Commission has not required submittal of the First Report of Injury within ten days after the knowledge or occurrence of an accident. From July 1985 to March 1986, 45% (20,931 of 46,452) of the reports were submitted 30 or more days following the accident. During the first four months of FY 85-86, 86% (18,304 of 21,207) of the injury reports received were submitted 11 or more days after the accident. The Commission has not assessed a fine until this form is 100 or more days late (see p. 80).

2. The Commission has not enforced Regulation 67-30, which requires physicians to file medical reports with the Commission 15 days after examination and final treatment, and states charges submitted by physicians not complying with this rule will not be approved by the Commission. The Commission does not monitor compliance (see p. 71), and could not provide information that would allow the Audit Council to determine the actual extent of the problem.

3. In violation of Regulation 67-9, the Commission has permitted carriers to make out drafts to the employee and his attorney (when applicable). Also, drafts have been delivered to attorneys when the attorney requested it. Regulation 67-9 specifies that "...all drafts...be made out and mailed or delivered direct to the employee, dependents or guardian" to ensure that the claimant or his surviving dependent(s) receive the correct amount of workers' compensation benefits. In one case reviewed by the Council, a Commissioner ordered that compensation payments be delivered to the claimant's attorney. On at least five different occasions, drafts were received by this attorney. In one instance, the attorney requested that a draft for $14,525 be made payable to him and his client. The Commission does not monitor to whom compensation drafts are made out or delivered and was not able to estimate the number of drafts sent to attorneys.

4. Although required by Regulation 67-25, the Commission has not required submittal of a Form 20 with the compensation agreement or at the time of the hearing in contested cases. Form 20 is the authorized statement of wages and days worked used to compute the average weekly wage, the basis for an injured employee's compensation rate (see p. 104). The Audit Council sampled 99 contested cases closed in 1984 and 1985 and found that a Form 20 was not filed in 61% (60 of 99) of the cases, and therefore was not available for computation of compensation.

5. The Commission has not ensured, as required by Regulation 67-5, that all employers operating under the

Act publicly post a notice of coverage for employee benefits (see p. 61).

Rules and regulations are state law. A 1979 Attorney General's Opinion states:

> ...it is the opinion of this Office that if a State agency has followed the procedures in the promulgation of rules and regulations...that such duly promulgated rules and regulations have the force and effect of law immediately upon going into effect.

According to Commission officials, some regulations are unrealistic. If the Commission wishes to change regulations, it should follow the procedures specified in the APA. These include giving public notice in the State Register, allowing participation by interested parties, and notifying the General Assembly before promulgation, amendment or repeal of any regulation.

The Commission's failure to enforce regulations involving submittal of claim forms, medical reports, compensation payments, etc., affects compliance and may affect the accuracy and/or timely delivery of claimant benefits. Also, when carriers are allowed to make out and deliver drafts to claimant attorneys, the Commission cannot ensure that the claimant or his surviving dependent(s) have received the benefits to which the claimant is entitled.

**Compliance With the Administrative Procedures Act**

The Workers' Compensation Commission has created and implemented agency decisions, as if they were state law, without statutory authority. Its powers are limited to those found in the state statutes and regulations. Rather than promulgate regulations, as required by the Administrative Procedures Act (APA), for areas where its actions affect the general public, the agency has internally approved and enforced new "regulations." These include: approval of lump sum settlements (see p. 24); regulation of

attorney and medical fees (see pp. 35, 44); and imposition of appeal fees.

Section 1-23-10(4) of the South Carolina Code of Laws defines a regulation as:

> ...each agency statement of public applicability that implements or prescribes law or policy or practice requirements.... [Emphasis Added]

This means that agency action that affects those outside its staff must be promulgated following requirements of the APA.

Regulation 67-19 authorizes the Commission to amend and adopt rules as needed. Although Commission officials stated they were aware that this provision did not exempt the agency from the APA, the Commission has not taken action to repeal this regulation. Also, a Commission official told the Council that Commission policies were adopted pending promulgation of regulations in the future. Section 1-23-130 permits agencies to immediately promulgate emergency regulations in the interest of the public health, safety, or welfare by filing the regulation and a statement of the situation with Legislative Council. However, the Commission has not promulgated any emergency regulations since the passage of the APA. Emergency regulations may remain in effect 90 days when the General Assembly is in regular session; otherwise, they can be renewed an additional 90 days. Further, these regulations become permanent upon meeting the previously stated requirements of the APA.

By not following the APA, the Commission has excluded the General Assembly and the public from review of its procedures in implementing the law. In addition, since the Commission has not complied with state law by promulgating regulations where necessary, the enforceability of agency policies when they affect the general public is questionable.

**RECOMMENDATIONS**

18. WHEN REGULATIONS AND AMENDMENTS TO REGULATIONS ARE NEEDED, THE WORKERS' COMPENSATION COMMISSION SHOULD PROMULGATE THEM AS OUTLINED BY §1-23-10 TO §1-23-160 OF THE SOUTH CAROLINA CODE OF LAWS.

19. THE WORKERS' COMPENSATION COMMISSION SHOULD TAKE ACTION TO REPEAL REGULATION 67-19.

## Control of Legal Costs

As workers' compensation systems have grown and become more complex, more claimants have retained attorneys to represent them, and formal legal proceedings, hearings, and appeals have become more common. Although the overall percentage of claimants who have attorneys remains small [4,600 of 75,225 (6%) of cases closed in 1986], evidence indicates that attorney representation is usually found in contested cases. For example, an Audit Council sample of back cases scheduled for hearings in FY 85-86, showed 95% (125 of 131) of the claimants retained attorneys.

The Workers' Compensation Commission did not enforce Section 42-15-90 of the South Carolina Code of Laws, which requires approval of attorney fees, until 1984. In that year, a study completed by the University of South Carolina for the State Reorganization Commission found that of 1,407 sample cases in which claimants were represented by attorneys from 1980 to 1984, 1,035 had no information about the fee amount. In August 1984, the Commission voted to require retrospective submission of attorney fees for approval from FY 81-82 through FY 83-84 and to require that henceforth all fees for claimants' and defense attorneys be approved by the Commission.

The first Commission policy suggesting a guideline for an appropriate amount was adopted in 1958 and remained in effect until 1987. Upon the recommendation of the Claimant's Attorneys, in January 1958, the Commission agreed:

> ...any contract for a contingent fee between the claimant's attorney and the claimant, not to exceed one third of the amount of compensation received, will be approved... [Emphasis Added]

In 1987, the Commission issued a new policy, fee petition, and guidelines.

**Promulgation of Attorney Fee Regulations**

The Workers' Compensation Commission has not promulgated regulations to approve attorney fees as required by law. Instead, Commissioners approve fees using individual discretion in interpreting guidelines adopted as Commission policy.

Section 42-15-90 states fees for attorneys in workers' compensation are subject to the approval of the Commission; in practice, the jurisdictional Commissioner acts for the Commission in approving individual fees. Further, it is a misdemeanor for an attorney to accept a fee unless it is approved by the Commission. Section 42-3-185 specifically states that any policies or procedures implementing the provisions of §42-15-90 are effective:

> ...only when such implementation is accomplished by regulations promulgated in accordance with the Administrative Procedures Act, which proposed regulations shall have before promulgation received approval of the Judiciary Committees of the Senate and House of Representatives and also by concurrent Resolution of the General Assembly. [Emphasis Added]

A 1980 Attorney General's Opinion stated that §42-3-185, passed in 1980, did not void existing rules, regulations and policies, but applied prospectively to new policies and

procedures implementing §42-15-90. However, as noted, the Commission has issued new policies to implement §42-15-90 since 1980 without promulgating regulations as required.

An Attorney General's Opinion of May 23, 1986 stated §42-3-185 requires the Commission to submit to the General Assembly for its review any policy or procedures related to the approval of attorney fees in compensation cases. Although the constitutionality of this section was questioned, the opinion stated that an administrative agency has no:

> ...discretion as to the recognition of or obedience to a statute. The agency must obey a law found upon the statute books until in a proper proceeding its constitutionality is judicially passed upon.

Ten of twelve other southeastern states surveyed by the Audit Council have attorney fee guidelines in statute or regulation, while the other two approve fees under the authority of policy. Five of seven South Carolina Commissioners stated attorney fees should be controlled by statute or regulation; four stated the General Assembly should be responsible for making policy on the issue.

By not making a formal statement of its policies in regulation, as required by the Administrative Procedures Act, the Commission does not provide claimants information that could be used to evaluate an attorney's fee requirements. Further, a Commissioner stated the exercise of unlimited individual Commissioner discretion in approving attorney fees has resulted in unfair fee approvals, and Commissioners are subject to undue pressure.

**Claimant Attorney Fee Approval Practice**

The Commission does not collect statistical data on the amount of claimants' attorneys' fees. The Audit Council manually reviewed case records which provided information about fees.

Commission records for contested back injury cases indicate that attorneys are complying in submitting their fees for approval, that the Commission approves their fees as submitted, and that claimants' attorneys are earning approximately 30% of the compensation benefits awarded to claimants who retain them. From an Audit Council sample of back injury cases scheduled for hearings in FY 85-86, data was retrieved from 88 closed cases on claimant attorney fee requests. The attorney's fee request was found in all but one of the files for cases in which compensation was paid. Although three of the seven Commissioners stated they have reduced claimant attorney fee requests from 5%-20% of the time, in the Audit Council sample one request was reduced by a Commissioner.

Of the $1,328,241 in eligible compensation benefits awarded in the sample, attorneys' fees of $397,823 (30%) were approved by the Commission. Attorneys' fees requested for individual cases in the sample ranged from $0 to $35,093.

While defense attorneys usually charge an hourly rate for their services, claimant attorneys usually operate on a contingency basis. That is, the lawyer's fee is a specified percentage of any recovery. Both the Audit Council sample and Commission data indicate the risk that no compensation will be awarded (and thus, no attorney fee) is approximately one in ten.

The laws in every state except Nevada contain provisions that control the fees of claimants' attorneys in workers' compensation cases. Of the 33 states which have issued guidelines on attorney fees as a percentage of benefits, only four states allow a percentage as high as one-third in any case, and one of those, Mississippi, allows one-third only in cases which are appealed to the court beyond the administering agency. In addition, Table 1 shows how 12 southeastern states surveyed by the Audit Council

have allowed a smaller percentage for claimant attorney fees than South Carolina.

**TABLE 1**

**ATTORNEY FEE REGULATION IN WORKERS' COMPENSATION**

**SOUTHEASTERN STATES**

| State | Fee Established | Maximum Allowable Fee Amount | Attorney Fees Approved |
|---|---|---|---|
| Alabama | Statute | 15% | Claimant Only |
| Arkansas | Statute | 30% first $1,000; 20% next $2,000; 10% balance | Claimant Only |
| Florida | Statute | 25% first $5,000; 20% next $5,000; 15% balance | Claimant Only* |
| Georgia | Regulation | 25% no hearing; 30% deposition; 33 1/3% hearing | Claimant Only |
| Kentucky | Statute | 20% first $25,000; 15% next $10,000; 5% balance; $6,500 maximum | Claimant Only |
| Louisiana | Statute | 20% first $10,000; 10% balance | Claimant Only |
| Mississippi | Statute | 25% before Commission; 33 1/3% if appealed to court | Claimant Only |
| North Carolina | Policy | 20% if no hearing; 25% if hearing | Claimant Only |
| South Carolina | Policy | 33 1/3% | Claimant and Defense |
| Tennessee | Statute | 20% | Claimant Only |
| Texas | Statute | 25% | Claimant Only |
| Virginia | Policy | case by case, average 12-15% | Claimant Only |
| West Virginia | Statute | 20%; 208 week limit per award | None |

*Annual report of defense fees required.

Source: United States Department of Labor, 1986, and Audit Council Research.

Since attorney fees comprise a significant cost of the workers' compensation system and are subtracted from and therefore reduce claimant's benefits, it is important that information be available on the amount of attorney fees to judge the impact on benefit adequacy. Safeguards should be provided to assure that the fees relate reasonably to the value of services provided.

National standards recommend that an attorney's fee should be based on the difference between the final award and the amount which the employer would have paid voluntarily. The amount of work performed by the attorney

in the case should also be considered; however, allowing a higher fee for cases that are carried to further stages in the hearing process (appealed, etc.) might increase the number of formal hearings and appeals. It is also not desirable to set attorney fees so low that claimants cannot get competent legal representation.

By not collecting statistical information about the level of the fees, the Commission has not given the General Assembly and the public the information necessary to make judgments about the public policy issues involved (see p. 54). If the Commission approved fees that were 5% lower than the current practice of 30%, an estimated $1.9 million annually could be reallocated from attorneys to claimants.

**New Policy**

The new fee petition adopted in March 1987 solicits information to aid Commissioners in determining the extent of the attorney's contribution to the claimant's award, such as the date the attorney was retained, whether liability in the case was admitted by the employer, and the amount and date of any settlement offer made prior to the attorney's service.

If the new guidelines are applied by the individual Commissioners, some approved attorney fees would be lower than in the past. For example, an attorney who received $12,000 of a $36,000 award in an admitted case under the old guidelines would now receive $9,175. Data was not available to allow the evaluation of the actual effect on fees of the new petition and guidelines, and as previously noted, until regulations are in place, enforcement is questionable.

**Administration of Claimant Attorney Fee Approval**

The Workers' Compensation Commission's procedures for approving attorney fees are time consuming and payment of

benefits to claimants is unnecessarily delayed. The Commission's new fee petition contains detailed guidelines and requires mathematical calculations to determine the appropriate amount of an attorney's fee. Four Commissioners stated the form is complicated, and two estimated that each takes 20-30 minutes to complete.

The fee approval process delays benefit payments. Claimants usually do not receive awarded benefits until the attorney's fee is approved. A Commission supervisor estimated that the process usually takes one to two weeks, although sometimes it can take up to a month.

Six of the seven Commissioners stated fee approvals that fit the guidelines should not be completed by individual Commissioners, but should be administratively handled. If the attorney disagreed with the administrative fee approval or the case was exceptional in some way, it should be reviewed by the hearing Commissioner.

Both Texas and Louisiana administratively approve claimant attorney fees; in Texas, approved fees are signed by the Board. In Georgia and North Carolina, attorney fees for cases that have formal hearings are approved by the hearing officer, and all other fees are administratively approved.

An administrative approval system could save Commissioners an estimated 1,200 hours per year. One Commissioner stated the time spent calculating attorney fees and corresponding about them could be better used in consideration of judicial matters.

**Approval of Defense Attorney Fees**

The Workers' Compensation Commission's practice in approving defense attorney fees is ineffective. Current requirements and procedures for defense attorney fee approval are unnecessary and wasteful. In addition, the Commission may not have the authority to approve the fees of defense attorneys.

Defense attorney fees are not critically reviewed at the Commission; the amount is not questioned. According to staff, when fee petitions are received from defense attorneys, approximately 5% are signed by a Commissioner. Ninety-five percent are processed by administrative personnel. Statistics are not kept on the amount of the fees, but only on the number of files processed.

Section 42-15-90 states "Fees for attorneys...shall be subject to the approval of the Commission..." and does not specify that this approval should apply only to the fees of claimant attorneys. However, an Attorney General's Opinion of May 23, 1986 states in workers' compensation a review of attorney fees is ordinarily limited to a review of fees paid from claimants' benefits. The opinion concludes:

> ...it is doubtful that §42-15-90 may be construed as presently authorizing approval...of employers' or carriers' attorney fees.

None of the 12 southeastern states contacted by the Audit Council regulate or approve the fees of defense attorneys. One reason a workers' compensation agency might require report of defense attorney fees is to collect information on the cost of attorney fees, as Florida does, as a part of monitoring the costs of the workers' compensation system as a whole. The National Commission on State Workmen's Compensation Laws recommended that attorneys' fees for all parties be reported. However, since the amounts of the fees are not compiled or statistically reported, the reporting of defense fees to the Commission does not currently add to information about the costs of the system.

Processing the defense attorney fees wastes the time and resources of Commission staff. In addition to the estimated 100 hours spent stamping and dating the estimated 4,800 petitions received annually, each petition requires that a case file be located, retrieved, and moved at least once, and then refiled. Furthermore, the procedure is

costly and inefficient to the defense attorneys, adding an estimated $240,000 to their costs annually.

**RECOMMENDATIONS**

20. THE WORKERS' COMPENSATION COMMISSION SHOULD IMMEDIATELY PROMULGATE REGULATIONS CONCERNING ATTORNEY FEE APPROVAL GUIDELINES AND PROCEDURES AS REQUIRED BY §42-3-185 OF THE SOUTH CAROLINA CODE OF LAWS.

21. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER WHETHER GUIDELINES OR MAXIMUM PERCENTAGES FOR CLAIMANTS' ATTORNEY FEES SHOULD BE SET IN STATUTE, TO BE IMPLEMENTED WITH REGULATIONS PROMULGATED BY THE WORKERS' COMPENSATION COMMISSION.

22. THE WORKERS' COMPENSATION COMMISSION SHOULD COLLECT STATISTICAL INFORMATION ON THE LEVEL OF CLAIMANTS' ATTORNEY FEES APPROVED AND MONITOR THE EFFECT ON CLAIMANT BENEFITS.

23. THE WORKERS' COMPENSATION COMMISSION SHOULD ALLOCATE ADMINISTRATIVE RESOURCES TO UNDERTAKE APPROVAL OF CLAIMANT ATTORNEY FEES. APPEALS OF FEE DECISIONS OR DIFFICULT AND UNUSUAL CASES COULD BE REFERRED DIRECTLY TO THE JURISDICTIONAL COMMISSIONER.

24. THE WORKERS' COMPENSATION COMMISSION'S ADMINISTRATIVE COMMITTEE SHOULD REVIEW

THE COMMISSION'S PRACTICE IN APPROVING DEFENSE ATTORNEY FEES.

25. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER WHETHER APPROVAL OF DEFENSE ATTORNEY FEES IS DESIRABLE, AND, IF SO, RECOMMEND APPROPRIATE LEGISLATION.

## Control of Medical Costs

Medical care expenditures for occupational injuries and illnesses covered by workers' compensation insurance have increased at a greater rate than the cost of medical care. From 1972 to 1983 the National Consumer Price Index for medical care commodities and services increased 180%; during the same time there was a 328% increase in medical care expenditures for workers' compensation. In South Carolina there was an increase of 324%, from $7,872,765 in FY 72-73 to $33,375,685 in FY 83-84. Medical costs are approximately 35% of all funds expended for workers' compensation in South Carolina.

The Workers' Compensation Commission's efforts to control and monitor medical services to claimants have focused on the fees that medical personnel and institutions charge their users.

### Regulations for Medical Fee Review

The Workers' Compensation Commission's policies and procedures for fee review have not been promulgated in regulations. Section 42-15-90 of the South Carolina Code of Laws states the fees of physicians and hospital charges are subject to the approval of the Commission, and that it is illegal for providers to receive fees that are not approved by the Commission.

The Commission maintains a Schedule of Fees for Physicians and Surgeons which represents its approved level of medical charges. In 1985, the Commission added hospitals to the schedule by instituting a system of per diem reimbursements for each hospital in the state.

The review process for promulgating regulations would ensure the public is adequately informed of the methodology used to determine the approved level of fees. When regulations for medical fee review are not in place, compliance by medical entities and carriers cannot be legally enforced. Noncompliance causes higher medical costs for the system, which could result in higher premiums for employers and consumers.

**RECOMMENDATION**

26. THE WORKERS' COMPENSATION COMMISSION SHOULD IMMEDIATELY PROMULGATE REGULATIONS FOR THE REVIEW OF PHYSICIAN AND HOSPITAL FEES AS REQUIRED UNDER THE ADMINISTRATIVE PROCEDURES ACT.

**Medical Fee Schedule Administration**

The Workers' Compensation Commission does not use its resources for maximum effect in medical fee review. The Commission places no lower limit on bills it will accept for review; the Medical Division reviews bills that are less than $20, although nearly all cost savings are obtained from reviewing bills greater than $100. In an Audit Council sample of 167 bills submitted for review, 54% were greater than $100, but these bills accounted for 94% of the savings.

Although the Commission has no regulations for these procedures, it asks carriers to submit physician and hospital bills which are not in compliance with the medical fee schedule for prepayment review. Compliance with the Commission's policies on medical fee review is at the discretion of insurance carriers and employers; the

Commission does not monitor bills that are not voluntarily submitted. In an Audit Council sample of 143 cases which involved permanent disability 12.6% of the physicians' bills were voluntarily submitted for review.

Current procedures for medical bill review do not maximize efficiency. Bills are reviewed manually and individual forms are typed for every bill that is reduced. Agency officials state bills remain in the Medical Division for an average of seven to ten days, and further delays result because the Commission mails the bills back to the carriers only twice a week. The Commission has not given priority to automation of the fee review process. Commission staff say that the limited size of the Medical Division (3) precludes review of any more bills than they now handle.

A national standard recommends that the administrative agency should "...take an active role in monitoring all payments made under the compensation statutes." Since §42-15-90 of the South Carolina Code of Laws makes it illegal for physicians and hospitals to receive more for a service than the amount approved by the Commission, the Commission should monitor payments to these providers.

Some other states with medical fee schedules review all bills for compliance. North Carolina has a manual prepayment review of all bills in cases which have more than $500 in medical expenses; an official stated they are able to return bills within a day of receipt. In Florida, which has an automated postpayment review of all bills, the agency can identify and discipline carriers that are not in compliance with the schedule.

Although the Medical Division does not keep statistics on the amount they reduce bills, in an Audit Council sample of 167 bills submitted for review, approximately 46% were not reduced. The remainder were reduced an average of $97 per bill. Based on this sample, in FY 85-86 the Medical Division's review of bills reduced workers' compensation

medical costs an estimated $1,660,000 and in FY 84-85, an estimated $2,077,000 was saved. However, if bill review procedures were more efficient and effective, costs could be further reduced, resulting in lower premiums and costs to consumers.

There is little incentive for doctors to comply with the fee schedule. Also, the lack of consistency in the Commission's review can cause reductions in some doctors' bills to be unfair and arbitrary, when identical bills are paid in full by insurance carriers who do not submit bills for review. Additionally, carriers who stress timeliness in payment of bills are hindered by a review that is not timely.

**RECOMMENDATIONS**

27. THE WORKERS' COMPENSATION COMMISSION SHOULD PROMULGATE REGULATIONS FOR MEDICAL FEE REVIEW:
    A. TO REQUIRE CARRIERS AND EMPLOYERS TO COMPLY WITH THE COMMISSION-APPROVED FEE SCHEDULES.
    B. TO REQUIRE THE SUBMISSION OF ALL PHYSICIANS' AND HOSPITAL BILLS GREATER THAN A COMMISSION-SPECIFIED AMOUNT THAT ARE NOT IN COMPLIANCE WITH THE MEDICAL FEE SCHEDULES.
    C. TO PROVIDE PENALTIES FOR NONCOMPLIANCE AND REGULAR MONITORING OF PAYMENTS.

28. THE WORKERS' COMPENSATION COMMISSION SHOULD IMMEDIATELY IMPLEMENT A POLICY OF REVIEWING ONLY BILLS GREATER THAN $100.

29. THE WORKERS' COMPENSATION COMMISSION SHOULD IMPROVE BILL REVIEW EFFICIENCY BY

ELIMINATING TYPED FORMS AND MAILING BILLS DAILY TO CARRIERS.

30. THE WORKERS' COMPENSATION COMMISSION SHOULD GIVE PRIORITY TO AUTOMATION OF THE FEE REVIEW PROCESS.

**Medical Fee Review Coverage**

Although the Workers' Compensation Commission is not authorized by law to review the fees of medical professionals other than physicians and hospitals, it has reviewed the fees of chiropractors since 1983 and of physical therapists prior to that time. The Commission does not review the fees of other health professionals, such as dentists, oral surgeons, and rehabilitation specialists.

Section 42-15-90 of the South Carolina Code of Laws specifies that, "Fees for attorneys and physicians and charges of hospitals for services under this title shall be subject to the approval of the Commission." Medical charges paid by workers' compensation include those for the services of a variety of health professionals, including dentists, chiropractors, physical therapists and rehabilitation counselors. The current law, by not allowing for the review of services by providers other than physicians and hospitals, is not consistent with the concept of cost containment.

**RECOMMENDATION**

31. THE WORKERS' COMPENSATION COMMISSION'S ADMINISTRATIVE COMMITTEE SHOULD RECOMMEND NEEDED CHANGES IN §42-15-90 REGARDING MEDICAL FEE REVIEW TO THE GENERAL ASSEMBLY.

## Out-of-State Medical Providers

The Workers' Compensation Commission has not reviewed the fees of out-of-state medical providers since approximately 1984, when a question was raised about the Commission's jurisdiction over these providers. In an Audit Council sample of 167 bills sent in for review, 12% (20) were from out-of-state providers. Currently, out-of-state bills are automatically approved for payment, regardless of the amount.

An Attorney General's opinion of October 21, 1986 questioned whether, in the absence of agreement by an out-of-state physician to be bound by South Carolina law, the South Carolina law requiring Commission approval of physicians' fees can be applied. The opinion suggested that the Commission procure agreements from participating physicians that they will be bound by the South Carolina Compensation Law.

The Commission has no data to determine the extent of the use of out-of-state physicians. However, in an Audit Council sample, 16.4% of the amount billed was for the services of out-of-state providers, which could amount to as much as $7.8 million in annual out-of-state medical costs. The use of out-of-state providers with no controls over their charges does not ensure cost containment to South Carolina employers and consumers.

## RECOMMENDATION

32. THE WORKERS' COMPENSATION COMMISSION SHOULD ASCERTAIN THAT CARRIERS AND EMPLOYERS ARE AWARE OF ITS FEE REVIEW POLICIES AND ENCOURAGE THE USE OF SOUTH CAROLINA MEDICAL PROVIDERS.

## Coverage Enforcement

There are several problems with the Workers' Compensation Commission's monitoring of workers'

compensation insurance coverage. First, the Commission has not been aggressive in its attempt to identify employers covered by the act who have four or more employees (see p. 85), but have not purchased insurance. The Commission attempts to detect uninsured businesses in the following ways: (1) through the receipt of a complaint or notification from a member of the general public, and (2) through follow-up if a first report of injury (12-A) is received without the employer and/or carrier code numbers. According to the Commission's Compliance Officer, employers without workers' compensation are often not discovered until an accident occurs.

Second, the Commission's computerized coverage system does not identify employers who become uninsured. Insurance carriers are required to notify the Commission when a policy is issued on an employer, when coverage is terminated, and when any policy amendments are made. Coverage information is then entered into a computerized system. However, insurance carriers are not always prompt in reporting changes, and the Commission's system, unlike Florida's, does not aid compliance staff in identifying potential problems by "flagging" employers who drop coverage without adding coverage with another carrier.

Additionally, Georgia and Alabama have accessed the National Council on Compensation Insurance's (NCCI) Policy Issue Capture System (PICS), which provides coverage information on policies issued in those states through an on-line computer system. A consultant's review of the Commission's information system (see p. 53) recommended that South Carolina contract with NCCI to use this system. In October 1987, the NCCI informed the Commission that it was discontinuing this service. However, according to the Commission, it is working with other states in an effort to persuade the NCCI to review this decision. The NCCI requires carriers to report renewal or nonrenewal of policies, and can therefore provide more accurate

information. The Commission, however, assumes coverage is continuous unless informed otherwise and does not require notices of renewal. Sections 42-5-30 and 42-19-50 of the South Carolina Code of Laws require carriers to file coverage reports with the Commission.

Third, the use of an employer code number assigned by the Commission, instead of a more standard federal employer's identification number (FEIN) used by other agencies, is inefficient (see p. 56). Georgia, Alabama and Florida each require carriers to submit the FEIN when policy information is reported. Absence of the FEIN impedes the Commission's efforts to detect uninsureds using information from other agencies.

The Prototype of an Administrative Workers' Compensation System, prepared for the American Insurance Association, suggests detecting uninsured employers by using the list of employers covered by unemployment compensation (UC) insurance. Those employers with UC insurance who do not have workers' compensation could be contacted concerning their status. Although the Commission has obtained the list of employers with UC insurance from the Employment Security Commission, it has not used the information to detect uninsureds.

Finally, the Commission has one compliance officer to investigate compliance problems for the state's 66,000 employers. Other states have more resources devoted to monitoring employers for coverage than South Carolina. Florida's and Pennsylvania's rates of detecting uninsureds, taking into consideration the relative number of employers in these states, are approximately 20 and eight times greater than South Carolina's, respectively. According to the Commission's compliance officer, sometimes it takes several days to determine whether the employer has four or more employees. Adoption of compulsory coverage for all employers with one or more employees would simplify enforcement (see p. 85).

There are several effects of coverage problems. In addition to the inefficient use of agency resources, the Commission cannot ensure that employers who are subject to the South Carolina Act are insuring their employees. Additionally, when employees of uninsured employers have injuries, they can be left without any income during the time they are unable to work, and also have to pay their own medical bills. Another effect is that uninsured businesses have an unfair business advantage in avoided costs over those in compliance. For example, one owner of a small business stated he pays approximately $13,000 for compensation insurance annually. The Audit Council identified a competitor who, as of 1985, should have been insured but never had workers' compensation insurance and, therefore, could have unfairly reduced cost of service.

**RECOMMENDATIONS**

33. THE WORKERS' COMPENSATION COMMISSION SHOULD ASSUME A MORE ACTIVE ROLE IN IDENTIFYING UNINSUREDS AND PROTECTING EMPLOYEES IN THE STATE BY TAKING THE FOLLOWING ACTIONS:
    - A. THE COMMISSION SHOULD FOLLOW THROUGH WITH ITS EFFORTS TO DETECT UNINSUREDS USING INFORMATION SUPPLIED FROM THE EMPLOYMENT SECURITY COMMISSION.
    - B. CARRIERS SHOULD BE REQUIRED TO SUBMIT THE FEDERAL EMPLOYER'S IDENTIFICATION NUMBER WHEN FILING NOTICE OF COVERAGE.
    - C. THE COMMISSION SHOULD CONTRACT WITH THE NCCI TO COLLECT COVERAGE INFORMATION IF THIS SERVICE IS CONTINUED.

34. THE WORKERS' COMPENSATION COMMISSION'S ADMINISTRATIVE COMMITTEE SHOULD CONSIDER RECOMMENDING AMENDMENTS TO §42-5-30 AND/OR §42-19-50 OF THE SOUTH CAROLINA CODE OF LAWS, TO ALLOW A THIRD PARTY TO COLLECT COVERAGE INFORMATION ON THE WORKERS' COMPENSATION COMMISSION'S BEHALF.

**Information System Development**

The Commission did not have an extensive automated information system for case management until 1983, when the Commission arranged to purchase a used computer from the Attorney General's Office. The Commission used this computer to begin development of an information system and has added additional hardware and software. However, the system is not compatible with other more commonly used computers; all of the hardware and software to support the system must be purchased from a single out-of-state vendor.

To adequately oversee the administration of benefits and adjudicate disputes, the Commission must process large quantities of detailed medical and legal information in a timely manner. Additionally, the Commission must collect and monitor information on the approximately 65,000 employers covered under the Act. In FY 85-86, 103,531 accident cases were filed with the Commission.

The information system has allowed the Commission to improve its handling of information, but several problems have limited its effectiveness. Decisions to adopt, expand, and develop the system were made by agency managers who had no computer training. Agency officials state training has been inadequate.

Agency officials state the lack of resources gave them little choice in selecting an information system, and subsequent decisions and priorities have been made on the basis of "putting out fires." The Commission has not

obtained sufficient resources to develop and manage its information system. For example, until 1986 just one professional was responsible for all information system needs of the agency. In November 1986, the agency proposed taking 82% of its state-mandated budget reduction for FY 87-88 from information system personnel and programs.

The Commission contracted with the Institute of Information Management, Technology and Policy at the University of South Carolina to undertake an information management review of the agency in spring/summer 1987. This study found that the current information system is not viable and recommended the Commission adopt a new system to be implemented by one of the computer service bureaus serving South Carolina state government.

**RECOMMENDATION**

35. THE WORKERS' COMPENSATION COMMISSION SHOULD ASSIGN HIGHER PRIORITY TO OBTAINING AND ALLOCATING ADEQUATE RESOURCES FOR THE DEVELOPMENT OF AN ADEQUATE AUTOMATED INFORMATION SYSTEM.

**Statistical Information**

The Commission does not collect adequate statistical information to allow the General Assembly and the public to evaluate program results. The Commission does not participate in programs in which states collect the uniformly defined statistics necessary to obtain a national comparative view of workers' compensation.

The Basic Administrative Information System (BAIS) requires collection of 25 uniformly defined items on cases. The Commission's system collects only 11 of the 25 items. The Commission does not participate in the Supplementary Data System (SDS), a federal/state cooperative program to collect occupational injury and illness data. Additionally, the Commission does not use national standard codes for

nature of injury/illness, occupation, or industry which would allow for comparison with other states.

The IAIABC recommends that the BAIS or its equivalent should be an integral part of each jurisdiction's program. Fourteen states have been certified as complying with BAIS, but an official with the IAIABC estimates that more than 25 states have substantially met these standards. Additionally, more than 30 states participate in the SDS, using national standard codes which specify the nature of the injury/illness, as well as the occupation and industry of the injured worker.

It is difficult to evaluate the results of the workers' compensation program in South Carolina. For example, the Commission does not collect data on whether or when injured employees returned to work, how many claimants are declared permanently totally disabled, the number of lump sum benefit payments, or the length of time it takes to resolve contested cases. Additionally, data on other issues of concern to the General Assembly and the public, such as the amount of attorney fees, or doctors' impairment ratings and fees, is not in the information system. This information can only be obtained by time-consuming manual examination of individual case files, protected by a confidentiality statute.

Further, meaningful statistical reports are not easily derived from data in the Commission's system. For example, the Director of Operations estimates that each Audit Council request for a report based on data available in the system required an average of 8-12 hours of programming time. As of March 1987, this agency administrator devoted in excess of 400 hours to Audit Council requests for information, approximately 23% of a year's work time.

**RECOMMENDATIONS**

36. THE WORKERS' COMPENSATION COMMISSION SHOULD ALLOCATE SUFFICIENT RESOURCES TO

IMPLEMENT THE BAIS INFORMATION SYSTEM AND SHOULD PARTICIPATE IN THE SDS INFORMATION SYSTEM.

37. THE WORKERS' COMPENSATION COMMISSION SHOULD STANDARDIZE INFORMATION COLLECTED ON NATURE AND TYPE OF INJURY/ILLNESS, OCCUPATION, AND INDUSTRY TO CONFORM TO NATIONAL STANDARD CODING PRACTICE.

**Management and Operating Information**

The Commission does not collect adequate management and operating information and is dependent on manual labor to perform duties which could be automated. In addition, the agency has not used standard numbers which would facilitate information exchange with state and federal agencies.

The agency's automated information system does not have information adequate to monitor benefit administration to claimants. For example, the system does not capture the date of first payment (see p. 65), collect information which could be used to identify cases which should be referred for vocational rehabilitation (see p. 82), aid in monitoring the progress of individual claims (see p. 69) or the medical treatment that claimants receive (see p. 71).

The agency does not have adequate information to effectively enforce the law regarding Commission approval of medical fees (see p. 71). Additionally, the Commission does not have adequate information to monitor insurance coverage of employers (see p. 49) or determine whether employers have rejected the Act (see p. 85).

Further, the Commission cannot easily implement some potential changes in the law. For example, if statutes were amended to provide cost-of-living increases in the benefits of permanently totally disabled workers, the Commission would have difficulty implementing the change. Because records are not kept of which workers have received

permanent total disability awards, staff would have to manually search thousands of files to identify these workers.

The agency uses its own unique employer code instead of the Federal Employer Identification Number (FEIN), and does not require the use of social security numbers on reports of injury. The social security number could be used to cross reference cases and the FEIN could be used to match data from the Employment Security Commission.

A national standard requires the workers' compensation administering agency to monitor all payments made under the compensation statutes, including voluntary payments and those made after dispute resolution. Management and operating information enables agency personnel to monitor, on a timely basis, the performance of employers and carriers, as well as agency staff productivity and workload.

Data matching aids in compliance efforts of agencies in detecting abuse. Currently, the Commission cannot utilize data matching to detect employers not in compliance with coverage requirements or individuals who abuse the system by filing multiple claims.

**RECOMMENDATIONS**

38. THE WORKERS' COMPENSATION COMMISSION SHOULD REQUIRE THE USE OF FEDERAL EMPLOYER IDENTIFICATION NUMBERS AND SOCIAL SECURITY NUMBERS ON ALL REPORTS OF INJURY OR COVERAGE.

39. THE WORKERS' COMPENSATION COMMISSION SHOULD EXPAND DATA COLLECTED IN ITS INFORMATION SYSTEM TO ASSURE THAT RELEVANT MANAGEMENT AND OPERATING INFORMATION IS AVAILABLE.

**Computer System Procurement**

The Commission did not comply with the South Carolina procurement laws in the purchase of its information system. Beginning with a system acquired from the Attorney General's Office, the Commission added to its system over a period of years with no written contracts.

According to §36-2-201 of the South Carolina Code of Laws, a contract in excess of $500 is not enforceable unless it is written. According to §11-35-2030, a contract for supplies or services cannot be entered into for any period of more than one year unless approved in the manner prescribed by State Regulation 19-445.2135.

From FY 82-83 through FY 85-86, the Commission spent approximately $778,860 on hardware and software for its information system from the same sole source vendors used previously by the Attorney General's Office. The Commission did not have a written contract with the vendors, with the exception of a maintenance contract, but paid the vendors as billed. Further, the Commission did not submit the multi-term determinations, required when a contract extends for more than one year, on its unwritten contracts with the vendors.

Written contracts are normal business practice and are for the protection of the seller and the buyer. A contract for equipment or services should spell out clearly the duties, rights, and responsibilities of each party, as well as penalties.

Without written contracts, the Commission has no protection that the equipment and services it purchases for its information system will be satisfactory. It has no guarantee that assumptions made about arrangements with vendors are correct.

For example, according to a Commission official, the Commission owns the software it pays a vendor to program; if the Commission lost its copy of a program, it could get another from the vendor without charge. However, without a

written contract, there is little to substantiate such a claim. Further, by not following the procedures required whenever a contract extends for more than one year, the Commission may have extended its unwritten contract with the information system vendors for a longer period than is desirable, and has not assured that costs are contained.

**RECOMMENDATIONS**

40. THE WORKERS' COMPENSATION COMMISSION SHOULD IMMEDIATELY NEGOTIATE WRITTEN CONTRACTS WITH VENDORS FOR ITS INFORMATION SYSTEM.

41. THE WORKERS' COMPENSATION COMMISSION SHOULD COMPLY WITH THE PROCEDURES FOR MULTI-TERM CONTRACTS AS SPECIFIED IN §11-35-2030 OF THE SOUTH CAROLINA CODE OF LAWS AND STATE REGULATION 19-445.2135.

**Forms Management**

More than 1.5 million forms are completed annually by participants in the workers' compensation system. Unnecessary time spent with forms may delay benefits to claimants and raise the costs of the workers' compensation system. Although the Commission is responsible by law for prescribing forms to be used in operation of the workers' compensation system, agency forms management has been poor. Additionally, agency coordination with the South Carolina Department of Labor to eliminate unnecessary reporting has been lacking.

The Commission has not instituted an ongoing forms management program for these external forms, or for the agency's internal forms, but has reviewed some forms periodically on an ad hoc basis. As a result, some forms

are outdated and incorrect, and agency forms do not follow some basic design principles.

For example, the agency's form 12-A, First Report of Injury, is densely packed with questions and cannot be completed using single-spaced typing. In addition to information needed by the Commission, the form contains data that can be used to satisfy federal Occupational Safety and Health Administration (OSHA) requirements for reporting occupational illness and injuries. However, 7 of 12 questions about the cause of accident are not needed by either agency.

The costs of producing forms are only a small portion of the total cost. A Federal Task Force Report on Paperwork Management estimated that the cost of processing and handling forms is 20 times the cost of paper and printing. The State Printing Officer of the Materials Management Office offers consulting services about forms design and content upon agency request.

Large amounts of time are wasted when people fill in unnecessary or poorly designed forms. If the forms were improved so that each form took 30 seconds less to complete, a time savings of more than 12,500 hours annually would result for those charged with completing the forms.

The Commission's Administrative Liaison Committee (see p. 72) has contributed suggestions about the agency's external forms, and the Executive Director plans to accompany the agency's developing policies and procedures manual with a forms control program.

**RECOMMENDATIONS**

42. THE WORKERS' COMPENSATION COMMISSION SHOULD INSTITUTE AN ONGOING PROGRAM OF FORMS MANAGEMENT AND CONTROL.

43. THE WORKERS' COMPENSATION COMMISSION SHOULD REQUEST THE ADVICE AND

CONSULTATION OF THE STATE PRINTING OFFICER ON THE DESIGN OF THE FORMS PRESCRIBED FOR THE WORKERS' COMPENSATION SYSTEM.

44. THE WORKERS' COMPENSATION COMMISSION SHOULD CONSULT WITH THE SOUTH CAROLINA LABOR DEPARTMENT TO AVOID DUPLICATION AND INCREASE EFFICIENCY IN REPORTING OF INJURIES.

**Public Information**

The Audit Council reviewed the Commission's efforts to inform the public of rights under the Workers' Compensation Act. The Council found that the Commission has not provided adequate assistance to handle public inquiries, monitored the posting of workers' compensation notices, or provided general information about the workers' compensation system. These problems are discussed in detail below.

**Public Inquiries**

The Commission has not established a program or coordinated agency staff to answer public inquiries. Also, the Commission has not provided access to a toll-free, long-distance telephone system to assist the public.

Questions and complaints involving workers' compensation claims and issues are routed to available staff in the agency's Claims Division. The Claims staff does not maintain a log of inquiries received by the Commission.

Position descriptions of the claims staff show each spends 15% of his/her time advising carriers and employees in the claims office and/or by telephone. A claims examiner told the Council that a person making repeated inquiries about a claim may on different occasions talk with different employees, and the claims staff may duplicate each other's

work by researching or reviewing a case that has already been examined.

The Claims Assistance Unit of the Georgia Board of Workers' Compensation provides two full-time staff for public information and assistance. In FY 85-86, this unit assisted 1,315 claimants who visited the Board and 33,081 claimants by telephone.

The Public Information Officer in Arkansas handles complaints and answers inquiries. This position was created in 1979 because the number of inquiries received did not allow examiners to complete their primary work. Workers' compensation agencies in Florida, Georgia, Tennessee, and Arkansas have toll-free telephone systems.

The Commission requested funds for the establishment of an ombudsman section and a toll-free long distance telephone system. However, the funding of both projects was the 13th priority of 14 requests for additional funds for FY 88-89. Funding requests receiving higher priority included the hiring of a mail room assistant (priority no. 5) and a file clerk (priority no. 6).

The Commission estimates that the first year's cost of the Ombudsman Section (including two professionals, one clerical assistant, and the telephone system) would be $105,951. The estimated annual recurring cost would be $91,882.

**Notice of Workers' Compensation Coverage**

South Carolina Regulation 67-5 requires that all employers operating under the Workers' Compensation Act publicly post a notice of workers' compensation coverage. However, the Commission does not provide resources necessary to review a representative sample of all identified businesses to ensure this information is available (see p. 31). Additionally, there is no penalty for noncompliance.

According to Commission staff, one employee is assigned to inspect posting in only those businesses with reported compliance problems. Although the Commission does not keep records on the number of businesses inspected, an agency official estimated that 130 employers were visited and inspected in FY 85-86. This figure represents less than .2% (130 of 65,010) of the state's businesses operating under the Workers' Compensation Act.

**Public Awareness**

The Commission has not made public service announcements explaining the workers' compensation system or sent informative materials (pamphlets, brochures, etc.) to persons filing workers' compensation claims.

The Commission's Director of Special Projects has planned and coordinated public displays and exhibitions concerning workers' compensation. The Director's job description states that he spends 5% of his time on these functions. Also, in 1987 the Commission simplified the workers' compensation notice.

The Audit Council found evidence that some claimants were not familiar with the workers' compensation system when they were injured. For example, a claimant told the Council he knew the purpose of workers' compensation but did not know how to file a claim, with whom to talk, or how to contact the Commission. In addition, this claimant stated that because his employer would give him no information, he hired an attorney to handle his case. Further, 7 (7%) of the 95 employers responding to a Council survey stated that they do not inform their employees about workers' compensation benefits. Finally, a Workers' Compensation Commissioner stated that claimants are not familiar with how the amount of compensation is determined or the evidence considered in settling claims.

Workers' compensation agencies in Florida, Georgia, Mississippi, Tennessee, and Virginia send pamphlets and

brochures to claimants upon receiving their first report of injury. Also, the Workers' Compensation Division of Tennessee makes public service announcements to inform the public of workers' compensation rights. An Audit Council survey of three television and two radio stations in Columbia revealed that public service announcements are offered at no charge.

**Conclusion**

A toll-free telephone system would provide equal access to the Commission for citizens throughout the state. Because the Commission has not logged workers' compensation inquiries, the nature of questions and/or complaints cannot be determined. Recording and analyzing these inquiries would provide information to identify problems within the workers' compensation system and allow the Commission to take action to rectify these problems.

Current Commission practice does not assure that employees are informed about their rights under the Workers' Compensation Act. Persons injured on the job may not apply for and/or receive benefits they are entitled to. Also, the lack of adequate information may cause claimants to hire attorneys. Unnecessary costs and delays in benefits may result. The Commission's establishment of a public assistance unit to respond to workers' compensation questions and complaints may expedite the claims process.

**RECOMMENDATIONS**

45. THE WORKERS' COMPENSATION COMMISSION SHOULD ENSURE THAT THE FUNDING OF A PUBLIC ASSISTANCE SECTION IS A HIGH BUDGETARY PRIORITY.

46. THE WORKERS' COMPENSATION COMMISSION SHOULD AMEND REGULATION 67-5 TO INCLUDE AN APPROPRIATE PENALTY FOR NONCOMPLIANCE

WITH THE REGULATION WHICH REQUIRES PUBLIC POSTING OF NOTICE OF WORKERS' COMPENSATION COVERAGE.

47. THE WORKERS' COMPENSATION COMMISSION SHOULD SEND INFORMATIVE MATERIALS TO WORKERS' COMPENSATION CLAIMANTS AND MAKE PUBLIC SERVICE ANNOUNCEMENTS TO INCREASE THE PUBLIC'S AWARENESS OF WORKERS' COMPENSATION.

**Delays in Benefit Delivery**

Although some delays in the process of benefit administration are unavoidable, the Commission has not taken sufficient steps to assure that delays are minimized. Examples of delays in the processing of cases noted elsewhere in this report include:

1. The Commission has not required the first reports of injury (12-A) to be submitted within the time period specified by regulation (see p. 31).

2. A reduction in the minimum notification time for hearings could advance the resolution of disputes in contested cases (see p. 98).

3. If the decision made by a single Commissioner is appealed to the Full Commission, an average delay of 77 days occurs between the request and the day the appeal is heard (see p. 95).

4. Claimant benefits are delayed until the Commission approves the attorney's fee (see p. 35).

Additional problems exist in this area. Regulation 67-28 states an opinion shall be issued within 60 days after an appealed case has been heard by the Full Commission. Although this regulation does not apply to single Commissioner orders, a policy to encourage issuing single Commissioner orders within 60 days was adopted by the agency in February 1985. The Commission, however, does not monitor

when orders are issued to determine the level of compliance with this policy.

The following section discusses problems with the timeliness of compensation payments to claimants and postponement of hearings. The cumulative effect of each of the above factors is that the overall timeliness of claims resolution is delayed.

**Timely Payment of Compensation**

Claimants are not assured of receiving temporary total (TT) disability payments within the time period specified by law. The Commission does not monitor when the first payment of compensation is made, and therefore, cannot effectively enforce penalties on employers/carriers who make late payments.

Section 42-9-230 of the South Carolina Code of Laws states the first installment of compensation payable under the terms of an agreement (see p. 100) is due 14 days after the employer has knowledge of the injury or death. Additionally, §42-9-240 states the first installment of compensation payable under the terms of an award, a Commission order of benefits due, is due within seven days from the date of such award. However, a third section, §42-17-50, allows the parties 14 days to appeal an award after it is given. Therefore, the requirement that the first installment is due within seven days of the award is inconsistent with the 14 days allowed for appealing the decision.

Further, §42-9-90 states that violations of timely compensation payment require that a 10% penalty shall be added to the unpaid installment to the claimant, unless the nonpayment is excused. The Commission does not monitor when any of these payments begin, and therefore, does not learn of violations unless they are pointed out by a claimant or other individual.

National standards advocate the prompt delivery of payments. IAIABC standards state, "The workers' compensation agency should take an active role in monitoring all payments made under the compensation statutes...."

Because the timeliness of first payment is not monitored, the incentive to make timely payments is reduced. Prompt delivery of benefits has been cited as likely to reduce litigation. Additionally, a change to the direct payment system recommended on page 102 could facilitate the timeliness of the first payment.

According to Commission officials, the agency is in the process of developing a system to capture information needed to detect when payments are made after an agreement. However, there are no plans to monitor when payments are made after an award. The Operations Director stated a lack of staff and resources prevents the Commission from monitoring the payments adequately.

**Postponement of Hearings**

The Workers' Compensation Commission has postponed hearings for other than legal reasons and has not imposed penalties as required by law against parties responsible for these delays. These postponements impede the timely delivery of benefits to claimants.

Regulation 67-31 states postponement of a scheduled hearing may be granted for only two legal reasons: attorney actually engaged in court of record; and inability of a party to appear due to sickness. A hearing cannot be postponed without the approval of the hearing Commissioner. The regulation also states an administrative cost not to exceed $50 shall be assessed against the party responsible for a hearing being postponed for other than a legal reason.

During the first six months of 1987, the Commission postponed at least 203 scheduled hearings. The Commission estimates the cost of scheduling a hearing to be $191. At least 55 (27%) of these hearings were postponed for other

than legal reasons as stated in Regulation 67-31. Reasons given by the parties requesting and receiving postponements included: attorney needs more time; request for a change of venue; and on one occasion an attorney asked that a particular Commissioner assume jurisdiction of a case. Other reasons given for postponing a hearing could be considered reasonable, although they fall outside the technical legal definition: attorney at Army reserves; or hazardous weather.

The postponement of a hearing delays the hearing of the case at least another six weeks. During a two-month period in 1987, the Judicial Department processed more than 90 cases that were being set for a hearing for at least the third time.

By not assessing fines for illegal postponements, Commissioners are not complying with the law, and the Commission does not recoup at least some of the costs incurred in rescheduling hearings. Additionally, there is little deterrence to requests for postponements.

**RECOMMENDATIONS**

48. THE WORKERS' COMPENSATION COMMISSION SHOULD MONITOR WHEN PAYMENTS BEGIN. EMPLOYERS/CARRIERS WHO DO NOT MAKE TIMELY PAYMENTS SHOULD BE ASSESSED THE 10% FINE REQUIRED BY §42-9-90 OF THE SOUTH CAROLINA CODE OF LAWS, TO BE ADDED TO THE UNPAID COMPENSATION.

49. THE WORKERS' COMPENSATION COMMISSION'S ADMINISTRATIVE COMMITTEE SHOULD CONSIDER RECOMMENDING TO THE GENERAL ASSEMBLY WHETHER §42-9-240 OF THE SOUTH CAROLINA CODE OF LAWS SHOULD BE AMENDED TO PROVIDE CONSISTENCY BETWEEN THE TIME PERIOD SPECIFIED FOR THE FIRST

INSTALLMENT OF COMPENSATION PURSUANT TO AN AWARD AND THE APPEAL PERIOD AS SPECIFIED IN §42-17-50.

50. THE WORKERS' COMPENSATION COMMISSION SHOULD ENFORCE REGULATION 67-31 CONCERNING POSTPONEMENTS AND ASSESS FINES FOR HEARINGS POSTPONED FOR OTHER THAN STIPULATED LEGAL REASONS.

51. THE WORKERS' COMPENSATION COMMISSION SHOULD AMEND REGULATION 67-31 TO ENSURE THAT ALL LEGITIMATE REASONS FOR POSTPONEMENT ARE INCLUDED (SEE P. 31). ADDITIONALLY, THE FINE SHOULD BE INCREASED TO REFLECT THE COST OF POSTPONEMENT.

**Claims Monitoring**

Claimant files are not adequately monitored to assure timely delivery of payments and prompt resolution of disputes. As a result, claimants may not receive benefits when they are needed and may suffer undue hardships.

The Commission averaged approximately 98,253 active files in FY 84-85 and FY 85-86. These files required monitoring by agency staff for forms documenting benefit payments or issues at dispute. A manager and six examiners in the Claims Division monitor active files, but there is no system to identify files for priority review, and files generally are not reviewed unless a hearing is requested. If this occurs, two claims analysts of the Judicial Division review files. Staff of the two divisions may then duplicate each other's work.

Examiners state that it is difficult to review open files due to other duties; these duties include assessing fines when insurance carriers do not submit the proper

document(s), handling correspondence on the files, and answering inquiries from claimants, insurance carriers, and attorneys. For claims filed in 1986, the Commission assigned each examiner approximately 2,100 claims to review over a six-week period. Two examiners told the Council that they could not fulfill their duties as assigned.

The Council reviewed 18 claimant files where a hearing had been requested. In 16 of the 18 cases reviewed, there was no evidence of a review by a claims examiner prior to the hearing request and necessary forms were missing. In one case, three forms requested on October 16, 1986 had not been submitted as of January 29, 1987. Since a hearing could not be set until the forms were submitted, the hearing was delayed.

An IAIABC standard states:

> The workers' compensation agency should take an active role in monitoring all payments made under the compensation statutes including voluntary payments and those made after dispute resolution.

Insurance companies and organizations that have claims handling functions commonly use automated information systems to flag cases which meet certain conditions, and print reminders to staff when specified actions are due.

An improved claims review process is important because it has a direct impact on benefit administration. If claims are not monitored adequately, claimant benefits and adjudication of contested cases may be delayed.

**RECOMMENDATION**

52. THE WORKERS' COMPENSATION COMMISSION SHOULD ALLOCATE RESOURCES TO IDENTIFY PRIORITY FILES AND ENSURE REVIEW OF CLAIMANT FILES ON A REGULAR BASIS.

**Physician/Medical Care Monitoring**

The Workers' Compensation Commission does not monitor the medical care received by claimants or enforce laws regarding the fees that medical providers are paid. The Commission's information system does not contain information on individual medical providers, their services, or bills. The Commission does not require that fees of physicians treating claimants be disclosed. Additionally, the Commission has no established procedures for dealing with complaints of medical providers' abuse of the system, such as allegations of doctors' charging high fees for favorable ratings, or overutilization in medical treatment.

A national standard states that the only assurance of quality medical care and reasonable cost is "...effective supervision of medical care and rehabilitation services by the State workmen's compensation agency." Some states assume responsibility for monitoring physical rehabilitation care in their rehabilitation units (see p. 82). Some states have automated systems to record and track medical care data which can be used to monitor fees and utilization of medical services.

Section 42-15-90 of the South Carolina Code of Laws makes it a misdemeanor for any physician or hospital to receive:

> ...any fee or other consideration or any gratuity on account of services so rendered, unless such consideration or gratuity is approved by the Commission.

The South Carolina Board of Medical Examiners investigates complaints about physicians' illegal, unethical or incompetent actions and takes disciplinary action. An official of the Board stated the Board has not received complaints from the Commission, but is prepared to act on complaints as they are received. Other regulatory boards have similar responsibility for other medical professionals, such as chiropractors and physical therapists.

Currently physicians and other medical providers are not held accountable by the Commission for their services to claimants. The law requiring physicians and hospitals to charge fees approved by the Commission is not enforced. There are no checks on abuses in utilization of medical care, impairment rating determination, or medical fees.

**RECOMMENDATIONS**

53. THE WORKERS' COMPENSATION COMMISSION SHOULD:

    A. PROMULGATE REGULATIONS REQUIRING FEES OF ALL MEDICAL PROVIDERS TO BE DISCLOSED TO THE WORKERS' COMPENSATION COMMISSION EXCEPT IN CASES WITH NO COMPENSATION AND MEDICAL BENEFITS UNDER $1,000 (SEE P. 73).

    B. DEVELOP AND MAINTAIN WRITTEN PROCEDURES TO ENSURE THAT ALL COMPLAINTS OF UNETHICAL, ILLEGAL, OR INCOMPETENT MEDICAL CARE ARE REFERRED TO THE SOUTH CAROLINA BOARD OF MEDICAL EXAMINERS OR OTHER APPROPRIATE PROFESSIONAL REGULATORY BOARD.

    C. INCORPORATE INFORMATION ON MEDICAL SERVICES AND FEES INTO ITS AUTOMATED INFORMATION SYSTEM.

    D. INFORM CLAIMANTS THAT IT IS ILLEGAL FOR PHYSICIANS TO ACCEPT MORE THAN FEES ALLOWED BY THE COMMISSION'S MEDICAL FEE SCHEDULE.

**Injury Reporting Requirements**

In fall 1986, the Workers' Compensation Commission established an Administrative Liaison Committee, composed of

members from within and outside the agency, to study the administrative procedures and requirements used by the Commission. In April 1987, on the recommendation of this committee, the Commission changed injury reporting requirements to more effectively allocate administrative resources.

Summary reporting is now allowed on all cases which involve only medical costs and have bills totaling less than $1,000. Due to this change, the Commission will annually save the time of four staff members, as estimated by the Audit Council. These resources can be reallocated to more detailed review of cases. If the current policy had been in effect in calendar year 1986, and just 80% of the carriers had used summary reporting, the Commission could have saved the time involved in processing an estimated 45,700 case files.

None of the workers' compensation administrative agencies in the ten other southeastern states contacted by the Audit Council require detailed reporting of small cases involving only medical costs.

However, the Commission has changed injury reporting requirements without appropriate changes being made in the law. Although new procedures provide a more effective allocation of resources, the Commission is technically in violation of the law. Section 42-19-10 of the South Carolina Code of Laws and Regulation 67-6 require that employers keep records of all on-the-job injuries. All injuries which require medical attention must be reported to the Commission within ten days. When small medical cases are reported in summary, the cases are not reported until they are closed, more than ten days after the accident.

**RECOMMENDATIONS**

54. THE WORKERS' COMPENSATION COMMISSION SHOULD CONTINUOUSLY MONITOR REPORTING

REQUIREMENTS TO ASSURE THAT THEY ARE REASONABLE AND GUARANTEE THE BEST USE OF ADMINISTRATIVE RESOURCES.

55. THE WORKERS' COMPENSATION COMMISSION SHOULD PROMULGATE REGULATIONS AS REQUIRED BY THE ADMINISTRATIVE PROCEDURES ACT TO ADMINISTER REPORTING REQUIREMENTS.

56. THE WORKERS' COMPENSATION ADMINISTRATIVE COMMITTEE SHOULD CONSIDER RECOMMENDING TO THE GENERAL ASSEMBLY AN AMENDMENT TO §42-19-10 OF THE SOUTH CAROLINA CODE OF LAWS CONCERNING INJURY REPORTING REQUIREMENTS.

**Regulation of Self-Insurers**

The Workers' Compensation Commission has not adequately evaluated the financial condition of self-insurers to determine if workers' compensation benefit payments are properly secured. The agency does not receive current audited financial information for many self-insurers and has not developed guidelines for interpreting this data through ratios and trends. As a result, the Commission may not have an adequate system to screen and detect financially weak self-insurers before they become insolvent and unable to pay compensation benefits.

Employers in South Carolina must obtain workers' compensation coverage through an insurance carrier or may self-insure if approved by the Commission. The primary purpose of regulating self-insurers is to make certain that their financial condition allows payment of short-term claims from current operating funds, and that long-term claims are properly secured. This is accomplished through monitoring current audited financial information and

determining if adequate security is available to pay claims in the case of bankruptcy.

As of February 1987, the Audit Council reviewed 34 (25%) of the 140 individual and group self-insurers. Although the Commission requires self-insurers to submit an audited financial statement annually, for 15 (44%) of the 34 self-insurers, there was no current audited financial information. Also, the Commission has not used other resources, such as evaluations by professional rating companies, to aid in monitoring the financial condition of self-insurers. The Commission had no published internal policy statements or regulations for monitoring the financial condition of self-insurers.

Until July 1985, one self-insurer had not submitted an audited financial statement to the Commission for approximately three years. The statement filed at that time indicated the self-insurer's financial condition was weak. Nevertheless, the Commission did not take any action until January 1986 when the self-insurer filed for bankruptcy. Although the security deposit proved to be adequate, the Commission indicated the security posted by the employer could have been inadequate to pay outstanding claims. The Commission had not required additional security to offset the employer's weak financial condition.

Iowa has developed a system of weighted financial ratios which act as an early warning system for self-insured companies whose financial strength begins to weaken. Florida also has developed guidelines to compute financial ratios and compare them to the average ratios in the self-insurers' industry.

Studies prepared for the American Insurance Association and by the Illinois Self-Insurers Association Task Force recommend developing guidelines for computing and using financial ratios to determine the financial condition of self-insurers. One study recommends reviewing a self-insurer's annual financial ratios for the past five

years and industry wide ratios for the past three years. These studies also recommend the use of professional rating companies to aid in monitoring the financial condition of large, publicly held corporations.

**RECOMMENDATIONS**

57. THE WORKERS' COMPENSATION COMMISSION SHOULD DEVELOP GUIDELINES FOR MONITORING THE FINANCIAL CONDITION OF SELF-INSURERS.

58. THE WORKERS' COMPENSATION COMMISSION SHOULD ENSURE THAT ALL SELF-INSURERS SUBMIT AUDITED FINANCIAL STATEMENTS ANNUALLY.

**Security Requirements for Self-Insurers**

Current security deposit requirements for self-insurers are not consistently applied and could not be determined in some cases. Also, these requirements do not consider the self-insurers' estimated future claim payments and financial condition. As a result, the Commission may require security deposits which are either too high or insufficient to cover the self-insurer's outstanding claims.

According to §42-5-20 of the South Carolina Code of Laws, the Commission must require self-insurers to make a deposit to secure the payment of compensation for which the company assumes liability. The Commission currently requires a security deposit of at least $250,000. It also requires the self-insurer to have specific "excess" insurance coverage which covers only payments which exceed a specified amount for a single (large) accident. For example, a self-insurer whose excess insurance coverage carries a $100,000 retention (deductible) would have to pay a maximum of $100,000 for a single catastrophic accident.

According to agency officials, the security deposit of not less than $250,000 must be at least equal to the deductible amount of the self-insurers' specific excess insurance coverage. This practice does not consider the estimated future claim payments and financial condition of the self-insurer. Instead, the deposit is based entirely on the occurrence of a catastrophic event.

As of February 1987, the Audit Council reviewed 34 (25%) of 140 individual and group self-insurers. Based on information available, 12 of the 34 (35%) did not have security deposits based on the deductible amount of the self-insurer's excess insurance coverage. The Audit Council could not determine how these security deposits were calculated.

With the Commission's practice, security deposits may not be equitable and adequate to cover the outstanding claims liability of a self-insurer if it became insolvent. For example, the loss information and payrolls of two self-insurers were reviewed for the past three years. Based on this information, each self-insurer's average estimated claims liability was determined. One self-insurer had an average estimated claims liability of approximately $650,000 but was required by the Commission to post a security deposit of $250,000, leaving $400,000 of unsecured claims. The other self-insurer had an average estimated claims liability of approximately $230,000 but was required by the Commission to post bond of $500,000 which would more than twice cover its outstanding claims.

Studies performed for the Illinois Self-Insurer's Association and the American Insurance Association recommend that security deposit requirements be based on the financial condition and estimated future claim payments of self-insurers. Florida and Iowa both base security deposit requirements for self-insurers on these criteria. Security deposit amounts are increased to keep in line with estimated

future payments as a self-insurer's financial condition weakens and are eased as its financial condition improves.

**RECOMMENDATIONS**

59. THE WORKERS' COMPENSATION COMMISSION SHOULD REQUIRE ALL SELF-INSURERS TO REPORT ANNUALLY THEIR ESTIMATED CLAIMS LIABILITY.

60. THE WORKERS' COMPENSATION COMMISSION SHOULD DEVELOP GUIDELINES FOR DETERMINING SECURITY DEPOSIT REQUIREMENTS FOR SELF-INSURERS. THESE GUIDELINES SHOULD INCLUDE PROCEDURES WHICH CONSIDER THE ESTIMATED CLAIMS LIABILITY AND FINANCIAL CONDITION OF THE SELF-INSURER.

**Verification of Tax on Self-Insurers**

The Worker's Compensation Commission has not verified the actual costs paid by self-insurers to operate their workers' compensation programs. These actual cost figures are reported by the self-insurers on their tax returns and are the basis for computing the workers' compensation tax and Second Injury Fund assessments. As a result, the agency has no assurance that the taxes or Second Injury Fund assessments are correct.

For 1985, the Commission collected worker's compensation taxes of approximately $1.5 million from 170 self-insurers. These taxes, plus approximately $8.5 million collected by the South Carolina Department of Insurance from private insurance carriers, are a 4.5% general tax levied on workers' compensation insurance (see p. 117). Also, Second Injury Fund assessments, which reimburse employers when a handicapped employee is injured on the job (see p. 115), totaled approximately $3.8 million for 1985.

The Audit Council reviewed 43 (25%) of the 171 self-insurers' tax returns filed for 1985. None of the actual costs reported by the self-insurers had been verified by the Commission. Figures reported on tax returns based on calendar year expenses could not be compared to the self-insurers' annual audited financial statements which are also submitted to the Commission. Tax returns are prepared based on calendar year expenses whereas financial statements are prepared based on the self-insurer's fiscal year, which may be other than a calendar year. However, audited financial statements that are based on a calendar year do not always break out expenses associated with workers' compensation to enable comparison with tax returns. In contrast, the South Carolina Department of Insurance verifies and audits cost figures reported by the private insurance carriers it regulates.

One self-insured company, which provided a breakdown of expenses with its tax return, included its previous year's tax expense of $124,000 in the tax computation. Other self-insurers did not include this expense. Another self-insurer reported claims expense of approximately $620,000 on its tax return. However, an audited financial statement of that self-insurer reported claims expense to be approximately $816,000 or 32% more than reported on the tax return. A third self-insurer refused to pay a Second Injury Fund assessment of approximately $64,000, claiming that other self-insurers were improperly reporting their actual costs on tax returns and receiving lower Second Injury Fund assessments.

**RECOMMENDATIONS**

61. THE WORKERS' COMPENSATION COMMISSION SHOULD CONDUCT RANDOM AUDITS OF SELF-INSURERS TO DETERMINE THEIR ACTUAL COSTS TO OPERATE WORKERS' COMPENSATION PROGRAMS.

62. THE WORKERS' COMPENSATION COMMISSION SHOULD DETERMINE THE IMPACT OF REQUIRING ALL AUDITED FINANCIAL STATEMENTS OF SELF-INSURERS TO INCLUDE A BREAKDOWN OF COSTS ASSOCIATED WITH OPERATING THEIR WORKERS' COMPENSATION PROGRAM.

63. IF A BREAKDOWN OF COSTS IS DESIRABLE, THE WORKERS' COMPENSATION COMMISSION'S ADMINISTRATIVE COMMITTEE SHOULD RECOMMEND TO THE GENERAL ASSEMBLY AMENDMENTS TO §42-5-190 OF THE SOUTH CAROLINA CODE OF LAWS THAT REQUIRE WORKERS' COMPENSATION TAXES TO BE FILED BASED ON THE SELF-INSURER'S FISCAL YEAR.

**Inconsistency in Fining**

To address previous inconsistencies in fining practice, the Workers' Compensation Commission adopted written policies and procedures for assessing and collecting fines and penalties in May 1987. However, these policies and procedures do not standardize the fine amount for the various filing violations, or standardize when fines are levied for late First Reports of Injury. They also do not address the Coverage and Compliance Division's responsibility for fining uninsured employers.

The Commission has the responsibility for ensuring that payments are made promptly and equitably and that claims are monitored thoroughly. The receipt and filing of prescribed forms is an integral part of this responsibility.

The following are examples of continuing problems in agency fining procedures:

- Claims examiners who levy fines for delinquent forms and also have discretion over the amount of the fine, apply fine amounts inconsistently. Additionally, the Judicial Division regularly fines employers/carriers $50 for the same forms for which claims examiners normally fine $100.

- Section 42-19-10 states the First Report of Injury is to be submitted within ten days of the occurrence or knowledge of the accident. According to claims staff, employers/carriers are usually fined if this report is over 100 days late, but a fine may be assessed if the report is less than 100 days late and, on other occasions, no fine is levied if the form is received after 100 days (see p. 31).

- The Commission has been assessing a $50 fine against employers found in violation of the Act instead of computing the minimum amount required by §42-5-40. For example, one employer in violation for over 17 months should have been fined at least $530; instead, a $50 penalty was assessed.

**RECOMMENDATIONS**

64. THE WORKERS' COMPENSATION COMMISSION SHOULD REVISE PROCEDURES FOR ASSESSING AND COLLECTING FINES AND PENALTIES TO ENSURE CONSISTENCY IN ENFORCEMENT OF LAWS REGARDING THE AMOUNT CARRIERS/EMPLOYERS ARE FINED AND WHEN THEY ARE FINED.

65. THE WORKERS' COMPENSATION COMMISSION SHOULD ADHERE TO §42-5-40 OF THE SOUTH CAROLINA CODE OF LAWS WHEN DETERMINING THE PENALTY AGAINST EMPLOYERS IN VIOLATION OF THE ACT.

## PART II
## STATUTORY ISSUES

### Adequacy of Benefits

The Audit Council reviewed the adequacy of workers' compensation benefits in South Carolina. The state meets some standards suggested by the 1972 National Commission on Workmen's Compensation Laws, such as the percent of wages replaced by compensation benefits (66.67) and the full payment of an injured worker's medical costs. However, there are problems in other areas, such as: inadequate vocational rehabilitation statutes; lack of mandatory coverage; and the lack of lifetime benefits for permanently and totally disabled workers. Additionally, compensation allowed for back injuries should be evaluated, and permanent total disability benefits to claimants with 50% back disability should be eliminated. The claimant should have a right to choose his own physician.

#### Vocational Rehabilitation

South Carolina statutes do not assure that vocational rehabilitation (VR) services will be provided to claimants who need them. Section 42-13-90 of the South Carolina Code of Laws specifies that VR is to be provided for victims of ionizing radiation, a small minority of claimants. However, statutes do not mandate VR be provided to victims of other work-related injuries, and therefore, the Commission cannot require it. Additionally, the Commission has no timely or systematic method of identifying claimants who could benefit from VR, and incentives for claimant participation are lacking.

Vocational rehabilitation is those services needed to restore the disabled employee to his/her preinjury employment or to a state of employability as close as possible to that which he/she enjoyed prior to injury.

Section 42-3-80 states the Commission's Administrative Director is responsible for referring all industrially injured employees that need vocational services to the Department of Vocational Rehabilitation (DVR). Insurance companies and/or employers may also provide VR services, but the Commission does not monitor these efforts.

DVR has a counselor stationed at the Commission. Approximately 525 referrals were made to DVR during 1986. National standards recommend that claimants missing at least three months of work be referred for VR consideration; over 2,500 claimants whose cases were closed in 1986 missed at least three months of work. Timely intervention and effective rehabilitation can reduce costs by shortening the period of temporary total disability and reducing the number of permanent total awards and settlements. However, a sample of 20% (105) of 1986 referrals made to DVR shows that in 62% of the cases, the referral was not made for more than a year from the date of accident.

Although data is not available to quantify cost factors, according to DVR, on the average, an individual successfully rehabilitated by that agency will pay taxes equal to 2.5 times the cost of his/her rehabilitation within 11 years. However, under the present situation claimants are not always identified and can refuse to participate. For example:

- A 42-year-old claimant suffering a back injury in 1984 refused to cooperate with DVR after being referred twice. His case was appealed to the full Commission where he was awarded over $80,000. As part of the Commission's order the claimant was again referred to DVR, but he would not participate and the Commission could not make VR mandatory.

- A 35-year-old claimant receiving a 25% impairment rating to the leg could not return to his former vocation. Although the claimant's case was settled with a clincher agreement for $37,000, there is no indication the claimant was ever referred for VR.

Several groups have studied and recommended key provisions of a successful workers' compensation

rehabilitative program. Among these groups and reports/studies are: the IAIABC; the Report of The National Commission on State Workmen's Compensation Laws (NCSWCL); The Council of State Governments (CSG); Prototype of an Administrative Workers' Compensation System (PAWCS); and the National Conference of State Legislatures (NCSL). Some major recommendations follow:

1. The formation of a rehabilitation division within the workers' compensation agency. The division should be responsible for assuring that VR services are provided and should monitor the delivery of services. (IAIABC, NCSWCL, CSG)

2. Early identification of those who should receive rehabilitation and prompt delivery of services. Claimants suffering catastrophic injuries should be referred for consideration immediately. Others should be referred for consideration if three months of work are missed. (IAIABC, PAWCS, NCSL)

3. Claimants should receive special maintenance benefits to help defray the cost of VR participation. (IAIABC, NCSWCL, CSG)

4. The Workers' compensation agency should have the authority to order VR services when indicated with provisions for the elimination or reduction of benefits/compensation for unjustifiable refusal. (IAIABC, CSG, PAWCS)

5. The costs of rehabilitation should be paid by the insurer/employer. (IAIABC, NCSWCL, CSG)

Thirty-three states have rehabilitation units that provide one or a combination of three types of services: direct (provided by the agency), monitoring, and/or referral. Approximately 40 states have provisions for special maintenance benefits during VR, including Florida and Georgia. Mandatory participation on the part of the claimant with penalties for refusal has been implemented in 23 states. In 30 states the insurer/employer is responsible for VR costs. Georgia and Florida each maintain a directory of qualified providers, public and private, from which the insurer/employer chooses a supplier. In addition, 13 states

have a limit on the amount of time an insurer/employer is required to pay for these services.

**RECOMMENDATIONS**

66. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY, WITH INPUT FROM THE DEPARTMENT OF VOCATIONAL REHABILITATION, CONSIDER BROADENING THE WORKERS' COMPENSATION COMMISSION'S VOCATIONAL REHABILITATION STATUTES.

67. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER CREATING BY STATUTE A REHABILITATION UNIT WITHIN THE WORKERS' COMPENSATION COMMISSION. AT A MINIMUM THE UNIT SHOULD HAVE RESPONSIBILITY FOR:
    A. EARLY IDENTIFICATION OF DESERVING CLAIMANTS.
    B. ORDERING REHABILITATION WHEN NECESSARY.
    C. MONITORING REHABILITATION EFFORTS.

**Workers' Compensation Coverage**

Compensation laws can be compulsory or elective. The South Carolina Act exempts specific types of employers from coverage and is not compulsory, allowing employers and employees to reject workers' compensation coverage. As a result, some employees are not protected under the provisions which provide compensation for personal injury or death by accident arising out of and in the course of employment. In such cases, the only recourse is to attempt loss recovery in the courts.

The South Carolina Act exempts the following: employers having fewer than four employees; agricultural workers; casual workers (those whose work is not permanent

or regular); employers with a payroll less than $3,000 for the previous year; federal workers; state and county fair associations; railway and railway express companies; and the Textile Hall Corporation (a corporation organizing and producing the Southern Textile Exposition).

Commission records show that 224 employers and 19,623 employees have rejected workers' compensation coverage since 1935. The Commission does not update records on rejections and does not know how many rejections are in effect currently (see p. 56).

The United States Supreme Court found compulsory workers' compensation laws to be constitutional in 1917, 18 years before the South Carolina Act was passed. As of November 1986, compulsory workers' compensation laws had been passed in 47 of the 50 states and the District of Columbia. Of the three states with elective laws (New Jersey, Texas, and South Carolina), New Jersey requires compulsory coverage with the exception of sole proprietorships or partnerships.

Nationally developed model legislation recommends compulsory coverage for employers with one or more employees, as do other national standards. The IAIABC standard for universal workers' compensation coverage states, "Neither an employer nor an employee should have the right to reject coverage...."

Exemptions from workers' compensation vary among the states. Farm workers are covered to some degree in 35 states and the District of Columbia. However, South Carolina, along with 14 states, exempts farm workers but permits voluntary purchase of workers' compensation insurance. Statistics compiled by the National Safety Council for 1986 show that the death rate and percentage of disabling injuries in the agricultural industry exceeded those in other industries, including construction and mining.

Numerical exemptions from workers' compensation coverage exist in only 14 states. All exemptions apply to employers with five or fewer employees. Interstate railroad and federal employees are exempt because they are protected by federal statutes. Casual workers are commonly exempt because of the difficulty in administering coverage.

The employees of employers who reject the act are not protected against income loss or catastrophic medical expenses caused by job related injury and/or disease. Also, the employer is not protected from lawsuits for employee injuries. Compulsory coverage with limited numerical and occupational exemptions would ensure a more equitable level of workers' compensation coverage.

**RECOMMENDATIONS**

68. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER AMENDING THE STATUTES TO MINIMIZE NUMERICAL EXEMPTIONS FROM WORKERS' COMPENSATION INSURANCE COVERAGE; CONSIDERATION SHOULD ALSO BE GIVEN TO LIMITING OCCUPATIONAL EXEMPTIONS TO CASUAL WORKERS, RAILROAD, AND FEDERAL EMPLOYEES.

69. THE WORKERS' COMPENSATION COMMISSION SHOULD DEVELOP A SYSTEM TO UPDATE REJECTION RECORDS.

**Permanent Total Disability From Back Injury**

Section 42-9-30(19) of the South Carolina Code of Laws specifies that a claimant with a 50% or more loss of use of the back is totally and permanently disabled. As a result, persons who may be able to work can receive total and permanent disability compensation for the maximum provided by the statute. Benefits for permanent total disability

extend for 500 weeks. Back disabilities less than 50% are compensated as a percentage of 300 weeks.

This aspect of the law relating to disability of the back creates a major discrepancy at the 50% impairment level. For instance, a claimant with a 45% disability rating to the back is entitled to 135 weeks of compensation while a claimant with a 50% disability rating is entitled to 500 weeks. Thus, a 5% difference in the disability ratings of these claimants results in one claimant receiving an additional 365 weeks (seven years) of compensation. This discrepancy, coupled with the fact that there are problems with the medical evidence used to determine the disability ratings (see p. 15), could lead to claimants receiving more or less compensation than deserved.

According to §42-9-10, permanent total compensation is paid to employees who as a result of a work-related injury are permanently unable to work. However, persons who can work, as may be the case of some workers with 50% or more loss of use to their back (§42-9-30), also receive permanent total benefits.

The Audit Council reviewed a case in which a Commissioner ruled that a claimant was permanently totally disabled as a result of a 55% loss of use to his back. This claimant continued to work after the order was issued and has, since his first claim, filed at least three additional claims. In two of these cases, only medical benefits were awarded. The third claim, which involves another back injury, was being scheduled for a hearing during the Audit Council's review.

North Carolina, which designates 75% loss of use to the back as total and permanent disability, is the only other southeastern state which defines a certain percentage of loss of use to the back as permanent total disability. In South Carolina, the Governor's Insurance Task Force for Workers' Compensation recommended that the presumption of total disability to injured employees suffering a 50% loss

of use of the back be removed. Further, 21% (7 of 33) of the insurers responding to an Audit Council survey stated that the permanent total disability provision for back injuries should be revised or reviewed.

The Commission's information system does not record permanent total disability awards (see p. 54). Therefore, the Council could not determine the impact of the statute relating to permanent total disability of the back since its passage in 1972.

In addition, the provision relating to disability of the back assigns a maximum of 300 weeks for loss of use. This means that a back injury resulting in less than 50% loss is compensated based on proportions of this 300-week period. For example, the compensation of a claimant with a 10% loss of use to his back would be calculated as 300 X .10 (30 weeks). Some other states offer compensation for longer periods when necessary. In Tennessee, the maximum periods of compensation for permanent total and permanent partial back injuries are, respectively, 550 and 400 weeks. The maximum compensation period for all back injuries in Mississippi is 450 weeks.

There is a substantial difference between the amount of compensation received when a claimant has less or more than 50% disability to the back. The involvement of claimant attorneys in cases regarding back injuries may be explained by this, and the complexity of such cases. An Audit Council review of cases closed in FY 85-86 showed that claimants were represented by attorneys in 10% (1,335 of 12,959) of the back cases as compared to 4% (2,872 of 75,562) of the other cases. An increase in litigation affects the workload of the Commission's staff and the timely settlement of claims. Furthermore, claimants and/or employers may undertake a time-consuming and expensive search for favorable physicians' ratings if the claimant's disability is close to 50%.

Finally, the National Council on Compensation Insurance (NCCI) estimates removing the 50% presumption of total and permanent disability from the back statute would reduce workers' compensation costs in South Carolina by .2% to .9%, an estimated decrease of $656,600 to $2,954,600 in FY 86-87.

**RECOMMENDATIONS**

70. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER AMENDING §42-9-30 OF THE SOUTH CAROLINA CODE OF LAWS TO REMOVE THE PRESUMPTION OF PERMANENT TOTAL DISABILITY FOR EMPLOYEES WITH 50% OR MORE LOSS OF USE OF THE BACK.

71. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER WHETHER THE MAXIMUM 300-WEEK BENEFIT PERIOD ALLOWED FOR PERMANENT PARTIAL INJURY TO THE BACK IS ADEQUATE.

**Permanent Total Disability Benefits**

In addition to the problem of some claimants with back injuries receiving permanent and total disability benefits unnecessarily, another problem is the limited duration of benefits for claimants who are permanently unable to work. Compensation for permanent total disability extends for a maximum of 500 weeks except for workers who have been determined to be paraplegic, quadriplegic, or suffering from brain damage. These persons receive compensation for life. In addition, permanently and totally disabled workers receive medical benefits for life.

Permanent total disability is the loss of, or the permanent loss of use of, any body part or function which renders the person unable to work. Section 42-9-10 of the South Carolina Code of Laws states:

> ...the loss of both hands, arms, feet, legs, or vision in both eyes, ...constitutes permanent total disability....

Also, §42-9-30(19) provides that 50% or more loss of use of the back constitutes permanent total disability (see p. 87).

An IAIABC standard states, "In case of total disability, benefits should be paid for the entire duration of disability." National standards also recommend that total disability should be paid for the duration of the worker's disability or for life, without any limitation on time or dollar amount.

A total of 44 states and the District of Columbia specify that a worker can receive permanent total benefits for life or the duration of the disability. Six states, including South Carolina, restrict permanent total benefits to less than life or the period of the disability. In these states, the duration of permanent total benefits ranges from 401 to 600 weeks (approximately eight to 12 years).

Since the Commission does not keep statistics on the number of permanent total disability awards (see p. 54), the Council was unable to determine the number of these awards for any specific time period. However, based on statistics published by the National Council on Compensation Insurance (NCCI) for 1981 through 1983, the Audit Council estimates that there were an average of 87 permanent total disability cases per year in South Carolina.

Because South Carolina law allows permanent total benefits to be paid for fewer than ten years, with the noted exceptions, claimants could suffer financial hardships when payments cease. One claimant who was awarded permanent total disability benefits (resulting from a back injury) told the Council that she began having financial problems when her benefits ended. This claimant, who is physically unable to work, was 34 years old when her benefits ended. If she had not been injured and worked until retirement, she

could have earned wages for approximately 28 years beyond the time her benefits ended.

Further, the duration of total and permanent benefits is not adequate for minors who are injured on the job. For example, the benefits of a minor permanently totally disabled at age 17 would end when the minor is approximately 27 years of age (an estimated 35 years prior to retirement).

The NCCI (see p. 113) estimates that increasing the duration of benefits in South Carolina for permanent total disabilities from 500 weeks to life would result in a 3.2% overall increase, an estimated increase of $10,505,000 for FY 86-87, in workers' compensation costs.

**RECOMMENDATION**

72. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER AMENDING §42-9-10 OF THE SOUTH CAROLINA CODE OF LAWS TO EXTEND PERMANENT TOTAL DISABILITY BENEFIT PAYMENTS FOR LIFE OR THE PERIOD OF THE DISABILITY.

## Choice of Physician

Choosing the treating physician in South Carolina workers' compensation cases is the responsibility of the employer. The injured worker cannot follow the normal method of physician selection, but must see the physician chosen by his employer in order to receive medical benefits.

South Carolina is one of 13 states which have employer choice of physician. Nine other states allow the employer to make the initial choice, but the physician can be changed by the state's administering agency in some cases, and by the employee in others. South Carolina's law has not changed in this regard since 1935. Employers feel that if employees selected their own doctors, they might choose unqualified physicians or those who would maximize impairment ratings.

However, the report of the National Commission on State Workmen's Compensation Laws stated:

> We recommend that the worker be permitted the initial selection of his physician, either from among all licensed physicians in the State or from a panel of physicians selected or approved by the workmen's compensation agency.

An IAIABC standard assigns the employer responsibility for providing immediate treatment of occupational injuries, but states "...thereafter the injured worker should have free choice of a treating physician." Further, nationally developed model legislation presents three alternatives for physician selection; all give the choice of physician to the employee. The injured worker can choose a physician either from a panel selected by the employer and approved by the administering agency, from a panel selected by the agency, or from all licensed physicians in the state.

If the employee has no choice of physician, he may lack confidence in the physician to whom he is assigned. Workers' compensation professionals have stated this lack of confidence can affect the success of his medical treatment. The medical opinions of the employer's physician are often questioned as biased by the employee, and this could be a potential cause for increased litigation.

**RECOMMENDATION**

73. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER AMENDING THE SOUTH CAROLINA CODE OF LAWS TO INSTITUTE A MORE EQUITABLE METHOD OF PHYSICIAN SELECTION.

    A. THE INJURED WORKER COULD CHOOSE HIS OWN PHYSICIAN, EITHER FROM A LIST SELECTED BY THE EMPLOYER AND APPROVED BY THE WORKERS' COMPENSATION COMMISSION, OR FROM A

LIST APPROVED BY THE WORKERS' COMPENSATION COMMISSION IN CONJUNCTION WITH THE SOUTH CAROLINA MEDICAL ASSOCIATION.

B. ALL PHYSICIANS ON THE APPROVED LIST, INCLUDING OUT-OF-STATE PHYSICIANS (SEE P. 49), SHOULD GIVE WRITTEN CONSENT TO BE BOUND BY THE REQUIREMENTS OF SOUTH CAROLINA WORKERS' COMPENSATION LAW.

**Maximum Disfigurement Benefits**

Contrary to state law, the Workers' Compensation Commission has awarded compensation for slight and minor disfigurement (see p. 18). However, because the statute limits workers' compensation benefits for disfigurement to 50 weeks, benefits may not be adequate for disfigurement of a serious and permanent nature.

Regarding the adequacy of the benefit period, of the 19 states with a maximum benefit period for disfigurement compensation, only 2 states, Wyoming (25 weeks) and Missouri (40) weeks, limit workers to a shorter period of benefits than South Carolina (50 weeks). Rhode Island allows a maximum of 500 weeks and has the longest benefit period. Among the southeastern states, Virginia, Alabama, and Tennessee, respectively, have maximum disfigurement benefit periods of 60, 100, and 200 weeks. In North Carolina, compensation for disfigurement is limited to $10,000.

The purpose of the statute and regulation concerning disfigurement is to provide adequate compensation for employees with serious and permanent disfigurement; limiting benefits to 50 weeks may not provide adequate compensation.

**RECOMMENDATION**

74. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY EVALUATE THE

ADEQUACY OF THE MAXIMUM BENEFIT PERIOD FOR DISFIGUREMENT.

## Burial Allowance

The maximum burial expenses allowed by the South Carolina Workers' Compensation Act for deaths resulting from work related injuries is not adequate. The burial allowance by statute has been $400 since 1955, lower than any other state.

The average burial allowance for workers' compensation in the 50 states and the District of Columbia is $2,181.

## RECOMMENDATION

75. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY EVALUATE THE ADEQUACY OF THE BURIAL ALLOWANCE PROVIDED BY §42-9-290 OF THE SOUTH CAROLINA CODE OF LAWS.

## Appeals Panels

### Background

The Full Commission is the first level of appeal in the South Carolina workers' compensation system. Decisions and orders of single Commissioners may be appealed by either party within 14 days from notice of the award. During calendar year 1986, 1,815 formal hearings were conducted by Commissioners and 463 appeals to the Full Commission were received; an estimated 25% of the first-level decisions were appealed. Full Commission decisions can be appealed to the Circuit Courts (158 in 1986) and then to the South Carolina Supreme Court or Court of Appeals (approximately 27 in 1986).

**Current Practice**

Since September 1986, three-member panels of the seven-member Commission have been hearing appeals of the decisions of individual hearing Commissioners. This has resulted in an improved appeals process. However, a problem exists with the South Carolina Code of Laws which requires the unanimous approval of all Commissioners for reviews to be conducted in panels. The arbitrary action of a single Commissioner can prevent the system from functioning.

Prior to 1981, §42-3-20 required Full Commission reviews to be conducted by six Commissioners, excepting only the original hearing Commissioner. Five or fewer Commissioners were allowed to do the reviews in the absence of other Commissioners. Section 42-3-20 was amended in 1981 to allow the Commission to conduct reviews in three-member panels. Until August 1986, the Commission did not have unanimous Commissioner consent, and at that time unanimous consent was given for a trial period only.

Panels have provided for a more efficient and effective review system. When appeals are considered by panels of three instead of six Commissioners, each hears approximately half as many cases per month as they previously heard. They can then devote more time to reviewing the cases and the law, and to meeting with other panel members to discuss the issues. Additionally, there is more time to write detailed opinions on cases that have novel questions of fact or law. The Judicial Director stated now fewer cases must be reheard because the Commission is unable to come to a majority decision.

That the panels allow for a more careful review of appealed cases may be illustrated by the change in number of decisions reversed since the system began. The Commission's appeals process has been criticized as a rubber stamp where Commissioners rarely reversed each other's decisions. Statistics published by the Commission on cases appealed in 1983 revealed that 6.6% of the single Commissioners'

decisions were reversed by the Full Commission. The Audit Council analyzed the results of 150 cases heard since the panels were implemented on September 22, 1986, and noted that 31 (21%) of the decisions were reversed under the new procedure. Additionally, a higher percentage of decisions were affirmed with modifications or amendments (16%) than in 1983 (4%), possibly indicating a more thorough review.

One reason for the previous low rate of reversals could be the legal requirement that, in all cases, four members of the Full Commission must vote for reversal before a hearing Commissioner's decision can be overturned. This means that when six Commissioners participate in the review, a two-thirds majority is required to overturn. However, if five or four Commissioners participate in the review, it is more difficult to obtain the four votes required to reverse a decision. A review of Commissioners' appeal vote sheets during the period September 1985 through January 1986 shows that all six Commissioners participated in 39% (34 of 87) of the reviews, while five Commissioners participated in 52%, four Commissioners in 8%, and three Commissioners in 1%.

The Commission has made an increased commitment to hearing appeals in a timely manner. A standby schedule of cases will be heard if a scheduled case is resolved before the hearing date. Cases appealed to the Commission in 1986 were heard an average of 77 days after the request was made. In contrast, a representative month of appealed cases scheduled for January 1985 averaged 136 days between the request and the scheduled hearing date.

Due to the complexity of the law and subjectivity of the facts in workers' compensation cases, as well as the heavy caseload of the hearing Commissioners, it is important that an effective review process be established. A research report on Michigan's workers' compensation system suggests that the "...primary responsibility of the Appeal Board should be the orderly development of a coherent, uniform body of law." The administrative structure of South

Carolina's appeals process is unique in requiring Commissioners to review each other's decisions (see p. 8). Other states have a separate appellate body.

**RECOMMENDATION**

76. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER AMENDING §42-3-20 OF THE SOUTH CAROLINA CODE OF LAWS TO REMOVE THE REQUIREMENT FOR UNANIMOUS AGREEMENT OF THE COMMISSION BEFORE USING THREE-MEMBER APPEALS PANELS.

**Administration of Hearings**

Improvement is needed in the Workers' Compensation Commission's administration of hearings to resolve contested cases. Conducting hearings in each county is inefficient and unnecessary. Also, the timeliness of settling contested cases could be improved by reducing the notification time for hearings.

**Hearing Sites**

Conducting hearings in each county is inefficient and unnecessary, and results in an increase in the number of days scheduled for hearings. If the employer and injured employee disagree on compensation, a hearing is scheduled to allow both parties to present evidence and arguments. Hearings, by statute, are held in the city or county where the accident occurred, unless otherwise agreed to by the parties and authorized by the Commission. Commissioners and court reporters must travel to seven districts (2 to 11 counties in size) and hold hearings in each county. Smaller counties can have as few as one or two hearings a month. However, 69% of hearings scheduled in FY 85-86 were scheduled in ten counties.

Facilities provided by the counties for hearings are not always adequate. For example, facilities in one county are not accessible to injured claimants in wheelchairs, and Commissioners have to leave some facilities when they close, whether or not hearings have concluded.

National standards require the agency to provide mechanisms for prompt adjudication of disputes. Florida holds hearings in regional offices and Georgia statutes allow that state to hold hearings in a county contiguous to the one where the accident occurred. The Social Security Administration (SSA) holds hearings at nine locations for the state. Federal regulations specify the SSA is to hold the hearing at a location convenient to the claimant if he is not capable of traveling to a SSA hearing site. The SSA also has provisions for reimbursing claimants for any miles driven over 75 in attending a hearing.

Commissioners' time is not effectively used in travel. For example, by establishing seven regional sites, the Commission could minimize travel time and reduce by up to 27% the number of days scheduled for hearings. Regional sites could also allow the Commission to secure more permanent and appropriate facilities and devote more time to individual contested cases. Additionally, savings, based on seven sites, would include over $6,900 annually in subsistence paid to Commissioners.

**Hearing Notification**

The 30-day required minimum period of notice for hearings results in a less timely resolution of contested matters. Cases are scheduled approximately six weeks prior to the month in which they are to be held. When a hearing is postponed, for any reason, the case is rescheduled, resulting in a delay of 30 to 60 days. Commission statutes do not specify the amount of notification time necessary. Therefore, according to an Attorney General's opinion,

Administrative Procedures Act (APA) provisions requiring 30 days notification apply.

North Carolina, Virginia, Florida, and the SSA allow between 14 and 21 days notice to all parties. The State Employment Security Commission, which is exempt by law from the APA notice requirements, gives ten days notice for hearings. The Council of State Governments' model legislation also suggests that at least ten days notice be given to all parties.

**RECOMMENDATIONS**

77. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER WHETHER §42-17-20 OF THE SOUTH CAROLINA CODE OF LAWS SHOULD BE AMENDED TO ALLOW FOR REGIONAL HEARING SITES TO BE ESTABLISHED. PROVISIONS FOR MILEAGE AND/OR MOVING HEARINGS IN CASES OF NECESSITY SHOULD ALSO BE CONSIDERED.

78. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER WHETHER §1-23-320 OF THE SOUTH CAROLINA CODE OF LAWS SHOULD BE AMENDED TO EXEMPT THE WORKERS' COMPENSATION COMMISSION FROM THE ADMINISTRATIVE PROCEDURES ACT'S NOTICE REQUIREMENT.

**Direct Payment System**

The agreement system mandated by the South Carolina Workers' Compensation Law hinders the efficient and effective delivery of benefits. Temporary total (TT) compensation payments are to begin within 14 days of the employer's knowledge of the injury or death. Before payments begin, the carrier must accept liability for the accident. Once liability is accepted for an accident which

causes an employee to miss more than seven days from work, the employer/carrier and the claimant must sign a compensation agreement (Form 15), which is filed with the Commission.

The 14-day period may not be sufficient for carriers to determine liability. If an employer/carrier is doubtful about the legitimacy of an accident, it may deny the claim, forcing the claimant to request a hearing to resolve the dispute. Claimants who are unable to work then have to go without TT or medical payments until the hearing is held, usually two or three months later.

Employers/carriers could be more inclined to deny questionable claims because they cannot easily stop payments after signing the agreement. Once compensation payments begin, they cannot be stopped until the claimant has: signed a form stating he/she has or is able to return to work; actually returned to work; or been heard in a stop payment hearing.

In contrast to the current agreement system, a direct payment system would allow carriers to begin TT compensation payments without requiring admission of liability. This should result in more timely delivery of payments on questionable claims now being denied. In 1986 40 states had the direct payment system. Additionally, national standards recommend use of the direct payment system.

Georgia and Florida statutes require carriers to begin compensation promptly or file notice to contest the claim within 21 days of knowledge of the accident. In Georgia carriers may stop payments by contesting a claim based on investigative findings within 60 days after the first payment is due. To stop payment after the 60-day period, carriers must submit a notice of suspension of benefits and evidence the claimant has returned to work or has been released to return to work. Under the direct system, carriers are required to communicate directly to the employee any intent to contest a claim or alter payments.

The Report of The National Commission on State Workmen's Compensation Laws states:

> When payments begin promptly, the extent of litigation probably will be reduced because employees will see they can receive benefits without legal assistance.

Both Commission and carrier expenses are increased by the current agreement system. Two Commission employees estimated they each spend between 20% to 33% of their time processing the agreements. Also, approximately $7,000 in mailing costs would have been saved in FY 85-86. Increased carrier expenses have a direct effect on the level of premiums.

**RECOMMENDATION**

79. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER WHETHER §42-17-10 OF THE SOUTH CAROLINA CODE OF LAWS SHOULD BE AMENDED TO INSTITUTE THE DIRECT PAYMENT SYSTEM TO INCLUDE:
    A. CARRIERS SHOULD BE REQUIRED TO BEGIN COMPENSATION WITHIN A SPECIFIED PERIOD OF TIME OR FORMALLY DENY A CLAIM.
    B. CARRIERS SHOULD ALSO BE ALLOWED TO TERMINATE PAYMENTS WITHIN A SPECIFIED PERIOD OF TIME, BASED UPON INVESTIGATIVE FINDINGS.

**Stop Payment Procedures**

Under the present system, carriers are forced to continue temporary total (TT) disability payments to claimants who are able to return to work, but do not, and refuse to sign a receipt for compensation. Section 42-9-260 of the South Carolina Code of Laws and Regulation 67-10

require a hearing and Commission approval prior to termination or suspension of benefits, unless the claimant signs a waiver. During the two to three months from request to hearing, the carrier must continue making payments, unless a settlement is negotiated.

Present requirements increase the operating and administrative costs of insurance carriers and the Commission. These cost increases can affect premium costs. The Commission estimates the cost of each case scheduled for a hearing at $191 and the cost per hearing held at $558. Approximately 19% (998 of 5,182) of the hearings scheduled in FY 85-86 were stop payment hearings.

Georgia and North Carolina allow carriers to suspend payments without a hearing. In Georgia, payments can be suspended ten days after the carrier submits a notice with supporting medical evidence that the employee can return to work without restrictions or has reached maximum medical improvement. If a claimant objects, the Georgia Board can issue an order reinstating benefits pending a hearing.

In North Carolina, procedures are similar. However, the North Carolina Commission reviews each suspension application for approval or denial. If the application is approved and the claimant's physician has given a rating of permanent disability, payments continue but are applied to the PPD award due the claimant based on the physician's rating (see p. 20). Claimants in North Carolina also have the right to a second doctor's opinion which can force the carrier to reinstate TT payments. In both Georgia and North Carolina, the claimant is notified by the carrier of its intent to stop payments, is given the opportunity to respond, and may request a hearing if one is desired.

If the decision to stop payments is based upon medical evidence it is imperative that the physician's opinion be as unbiased as possible. Therefore, the claimant's right to choose his treating physician through an approved process

should be considered an integral part of this process (see p. 92).

Nationally developed model legislation recommends the practice of suspending payments with carrier notice to the administering agency, and national standards require benefits to be paid during the entire duration of disability. However, under the present system, payments can continue beyond the period of disability. As long as a claimant can continue to receive payments, there is less incentive to settle a claim and return to the work force.

**RECOMMENDATIONS**

80. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER WHETHER §42-9-260 OF THE SOUTH CAROLINA CODE OF LAWS SHOULD BE AMENDED TO ELIMINATE THE REQUIREMENT FOR AN EVIDENTIARY HEARING, UNLESS THE CLAIMANT WAIVES THIS RIGHT, PRIOR TO SUSPENSION OF BENEFITS.

81. IF THE GENERAL ASSEMBLY CHOOSES TO AMEND §42-9-260 OF THE SOUTH CAROLINA CODE OF LAWS, THE WORKERS' COMPENSATION COMMISSION WITH ADVICE FROM THE ADMINISTRATIVE LIAISON COMMITTEE SHOULD AMEND REGULATION 67-10 AS NECESSARY.

**Average Weekly Wage Law**

The average weekly wage (AWW) law used to determine an injured employee's weekly compensation rate may be inequitable to workers and is costly and inefficient to administer. Additionally, the Workers' Compensation Commission has not enforced the law and regulation concerning the AWW.

Section 42-1-40 of the South Carolina Code of Laws defines average weekly wages as:

> The earnings of the injured employee in the employment in which he was working at the time of the injury during the period of fifty-two weeks immediately preceding the date of the injury ...divided by fifty-two.

For each period in which the employee was absent from work more than seven consecutive calendar days, the days missed are subtracted and the resulting number of weeks worked is used in the calculation. The Commission's Form 20 (Statement of Days Worked and Earnings of Injured Employee) requires that the employer record the worker's daily attendance and monthly wages for an entire year prior to the date of accident.

Regulation 67-25 requires:

> In all cases, Form No. 20...must be submitted to the Commission along with agreement as to compensation or at the time of the hearing in contested cases.

However, the Commission does not enforce this regulation (see p. 31). Although the Commission does not keep records on how many Form 20s are submitted, the Audit Council estimates, based on a representative month's data, that approximately 2,870 are received in a year. Since approximately 18,000 agreements to compensation were made in FY 85-86, compliance with the regulation is estimated to be less than 16%.

Further, the Commission does not require the form be complete or correctly filled in to compute the AWW. An Audit Council sample of 128 forms revealed that 53 (41%) were computed without a year's worth of data and some used only two or three months.

According to members of the Commission's Administrative Liaison Committee (see p. 72), it is time consuming and difficult for employers to attempt to recreate attendance and pay records for employees. In some cases, the Form 20

must be computed long after the accident. For example, in 1987 an employer had to furnish an employee's work attendance and pay record from October 1983 to October 1984.

An injured worker's payments should be based on the wages lost because he cannot work. An AWW is determined as an attempt to get an accurate figure of what the employee usually earns, instead of what he earned at one point in time. Both Georgia and Florida determine an employee's average wage based on actual gross wages earned in the 13 weeks preceding the injury. Additionally, national standards suggest using either the employee's current salary or a 13-week period of wage data.

South Carolina's AWW law can be inequitable to workers. When the AWW is calculated, any period in which the employee missed seven consecutive days or more is subtracted from the number of weeks worked. This penalizes workers who have not taken seven consecutive days off for vacation or illness during the preceding year. To demonstrate, consider two workers who were paid an identical amount of $15,000 over a 52-week period. One of the workers took just a few days of vacation and sick leave, while the other took three weeks of vacation and sick leave for another three-week period. The worker who took extended vacation and sick leave would have an average weekly wage of $326, while the worker who did not would have an average weekly wage of $288.

Using a sample of 99 cases for which both current salary and average weekly wage data was available, the Audit Council found the AWW was greater than the current salary in 55 cases, and less in 44; the overall average difference between the two would result in a $5.86 difference in weekly compensation. Using a 13-week period of wage data would be as accurate as the 52 weeks now required and would have no significant effect on employers' costs or workers' benefits.

Commission employees who compute the AWW spend more than one-half of an employee's yearly work time figuring Form 20s, and staff estimate the Commission's time

represents only a fraction of the time required for employers to complete the forms. Compliance could improve if the requirement were based on data that most employers could readily produce, and more accurate wage reporting could be expected.

**RECOMMENDATION**

82. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER WHETHER §42-1-40 OF THE SOUTH CAROLINA CODE OF LAWS SHOULD BE AMENDED TO REQUIRE THAT AN EMPLOYEE'S AVERAGE WEEKLY WAGE WOULD BE DETERMINED BASED ON THE WAGES EARNED DURING THE 13 WEEKS IMMEDIATELY PRECEDING THE INJURY.

**Employee Claims**

The Workers' Compensation Commission has adjudicated claims filed by its staff, including one Commissioner. This results in a potential conflict of interest.

Between 1978 and 1987, 34 Commission employees filed a total of 43 workers' compensation claims. Although many claims involved medical benefits only, in six cases, the claim involved a permanent disability, and thus required Commission adjudication.

In 1984, legislation was introduced which called for the adjudication of workers' compensation cases involving Commissioners and their families through the Circuit Court system. This legislation was not enacted by the General Assembly. In addition, in 1985 the Commission requested that the Chief Justice of the South Carolina Supreme Court designate a Circuit Court judge to hear the workers' compensation cases of Commission employees and their families. The Commission requested that the cases of State Fund and Second Injury Fund employees and family members should be handled in the same manner. However, the Chief

Justice declined this request, stating that such a procedure would violate the doctrine of separation of powers.

The General Assembly's stated purpose for the State Ethics Law was "...to insure that conflicts of interest of public officials and employees be eliminated to the extent possible." Nevertheless, because §42-3-20 of the South Carolina Code of Laws authorizes Commissioners to hear all contested cases and conduct informal conferences, the Commission has no option to refer cases elsewhere, although there may be an appearance of impropriety. Therefore, without a change in state law, the Commission cannot avoid a potential conflict of interest and a possible ethics violation.

**RECOMMENDATIONS**

83. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY EVALUATE WHETHER THERE IS A CONFLICT OF INTEREST WHEN THE WORKERS' COMPENSATION COMMISSION ADJUDICATES THE CLAIMS OF ITS EMPLOYEES, AND, IF SO, CONSIDER ENACTING NECESSARY LEGISLATION.

**Administration of the Insolvency Fund**

The administrative costs of the Workers' Compensation Insolvency Fund are not being paid by the insurance carriers and self-insurers that sustain the Fund. Instead, state and local governments are paying the administrative costs although they are not required to pay into the Fund.

The Insolvency Fund insures the payment of benefits which are unpaid because of the insolvency of employers who failed to acquire necessary coverage for their employees. The Fund is maintained through taxes charged to workers' compensation insurance carriers and self-insurers.

Section 42-7-200 of the South Carolina Code of Laws established the Insolvency Fund in 1982 and designated the

State Workers' Compensation Fund (State Fund) responsible for administering it. For this reason, the administrative costs of the Insolvency Fund are paid by state and local government agencies who pay premiums into the State Fund.

The costs to administer other special funds in South Carolina are spread to those that are assuming the risk for the funds. For example, the Second Injury Fund was established to encourage the hiring of the handicapped by spreading the risk among all employers operating under the workers' compensation Act. These employers/carriers who sustain the Fund also pay the costs of administering it. The Insolvency Fund was established to spread the risk of insolvent employers among all who operate under the workers' compensation law.

Additionally, the South Carolina Insurance Guaranty Association in a similar function to the Insolvency Fund, administers the claims of insolvent insurance carriers. It is funded through assessments of licensed insurance carriers. Unlike the Insolvency Fund however, the carriers which have assumed the risk for insolvency also pay the costs to administer it.

According to State Fund records, 25 insolvency claims were filed in FY 84-85 and 15 in FY 85-86. However, in FY 86-87, the number of insolvency claims filed increased to 46, indicating that administrative costs could also increase.

The Second Injury Fund, like the State Fund, is administratively set up to handle workers' compensation claims. However, the Second Injury Fund is funded approximately 90% by insurance carriers and self-insurers and 10% by state and local government, whereas the State Fund is funded 100% by state and local government. By placing the administration of the Insolvency Fund under the Second Injury Fund, the administrative costs would be shared by those that sustain the fund (insurance carriers and self-insurers).

**RECOMMENDATION**

84. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER WHETHER §42-7-200 OF THE SOUTH CAROLINA CODE OF LAWS SHOULD BE AMENDED TO PLACE THE ADMINISTRATION OF THE WORKERS' COMPENSATION INSOLVENCY FUND WITH THE SOUTH CAROLINA SECOND INJURY FUND.

## PART III
## WORKERS' COMPENSATION COST FACTORS

### Comparisons of Workers' Compensation Costs

Statistics which compare the cost of workers' compensation insurance in various states are of limited validity. However, the most definitive analyses of comparative costs used by the Audit Council show that costs in South Carolina have since 1972 been consistently below both the national and southeastern averages.

Each state has its own workers' compensation law, and the way the system is administered, for example, by courts or commission, varies. The level and categorization of benefits as well as the composition of the labor force varies significantly from state to state. Some industries and occupations are safer than others; a state with a higher percentage of hazardous industries will have higher costs. The differences in wage levels across the nation also affect the amount of benefits paid, and thus, the costs. Other factors, such as medical costs and service availability, percentage of self-insurers, attorney involvement, and the philosophy and efficiency of benefit administration can also influence cost comparisons.

A final significant reason that meaningful comparisons are difficult is the "moving target" nature of workers' compensation. Changes in rates and laws are occurring constantly, and any comparison can only be for a single point in time. One 1986 rate comparison, for example, compared states on the basis of rates which differed by more than three years in effective date. A state which had a rate hike the day before the comparison could be compared to a state which had its last rate adjustment three years earlier.

The most meaningful comparison to employers would measure what an employer with the identical business and labor force would pay for workers' compensation in various

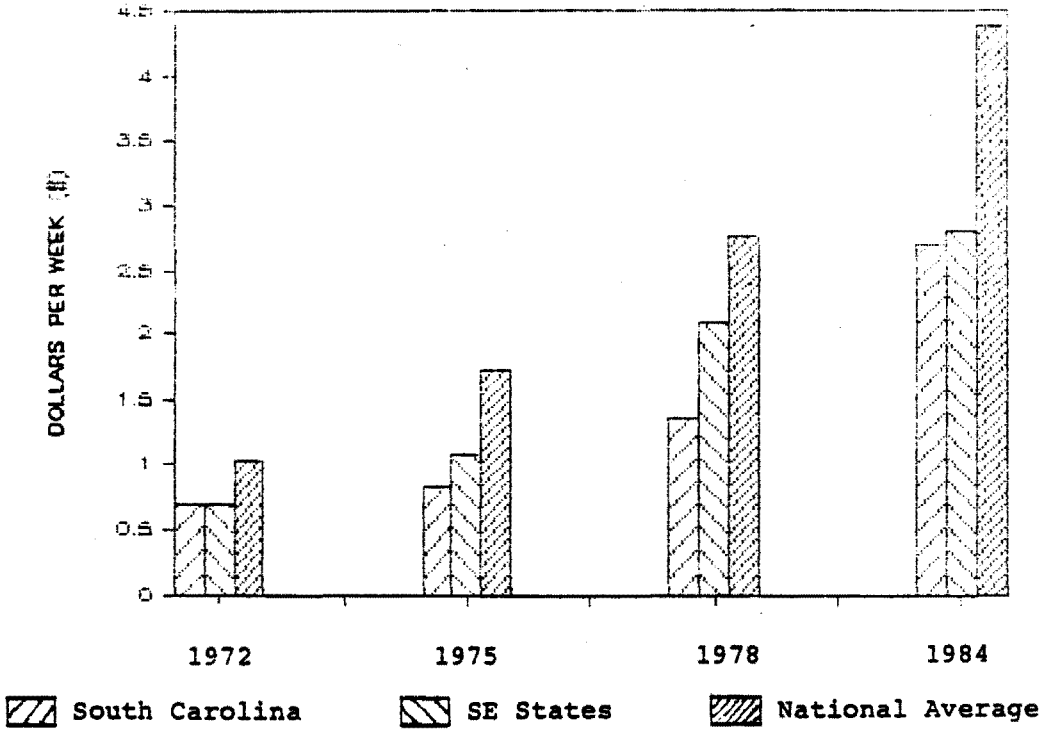
states. The Audit Council used the methodology of the leading experts (see p. Appendix D) on comparative costs of workers' compensation to obtain such a comparison. Due to lack of data, comparisons could not be made for self-insured organizations, which accounted for approximately 16-17% of the benefits in South Carolina in 1981 and 1982.

These tentative comparisons in employers' costs for workers' compensation show that, at the times for which data is available, South Carolina's costs have been consistently lower than both the national average and the average of ten southeastern states (see Figure 2). On January 1, 1984, South Carolina ranked 35th out of 47 states for which data is available.

**FIGURE 2**

**WORKERS' COMPENSATION COMPARATIVE COSTS**

**EMPLOYERS' NET COST PER WORKER**




Source: Table 2 (Appendix E).

## Workers' Compensation Insurance Rate Determination

The cost of workers' compensation insurance in South Carolina has a direct relationship to the benefits provided by the system. Insurance rates are not dictated by insurance companies, but are subject to analysis by both the South Carolina Department of Insurance and the South Carolina Division of Consumer Advocacy. Staff of both agencies believe that this process has safeguards which are likely to result in rates which are "fair, reasonable, adequate and nondiscriminatory," as required by §42-5-90 of the South Carolina Code of Laws.

By law all insurance companies must charge the same rates in South Carolina; carriers may compete by offering policyholders dividends or services, such as loss control. Some other states allow open competition or deviations from the established rates. Since 1981 ten states have adopted competitive rating. However, due to the individual differences in each state's system and insufficient data on the effect of recent changes in rating methods, the Audit Council could not evaluate the different systems comparatively.

The National Council on Compensation Insurance (NCCI), the principal national rating advisory bureau for workers' compensation insurance, collects and processes financial data from member insurers and files, on behalf of its members, for changes in rate levels in 31 jurisdictions, including South Carolina. The NCCI assesses projected future costs of claims reported by insurers and calculates the projected effect of changes in the state's benefit levels, such as an increase in the state's average weekly wage. The NCCI also includes projections of other costs charged to insurers, such as the assessment for the South Carolina Second Injury Fund (see p. 115) and the state's 4.5% premium tax (see p. 117), and estimates projected company expenses in administering benefits.

Before rates are put in place, the NCCI makes rate filings to the South Carolina Department of Insurance. The Insurance Department chief casualty actuary analyzes the data submitted by NCCI, as well as other independently collected data, and prepares his estimate of the appropriate rate level. As provided in the law (§42-5-90), the South Carolina Division of Consumer Advocacy also evaluates the rate filing and contracts with actuaries and other experts to prepare its estimate of the appropriate rate level.

After a public hearing, the Chief Insurance Commissioner issues an order setting the new workers' compensation rates. For example, in October 1985 the NCCI proposed a rate increase of 28.6%. The Insurance Department recommended an 8.9% increase and the Consumer Advocate recommended a 1.2% increase. The Commissioner's order approving an 8.9% increase was accepted by the Division of Consumer Advocacy, but was appealed by the NCCI to the Circuit Court where the decision was upheld.

Any effort to lower the costs of workers' compensation insurance in South Carolina must focus on the benefits and other obligations imposed on insurers by the law, and evaluate in each case whether what the system provides is worth the price that is paid.

**RECOMMENDATION**

85. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE WORKERS' COMPENSATION STUDY AND REVIEW COMMITTEE CONSIDER MONITORING WORKERS' COMPENSATION PREMIUM RATES IN SOUTH CAROLINA AND OTHER STATES, ESPECIALLY THOSE USING COMPETITIVE RATING, TO ENSURE THE SOUTH CAROLINA PROCESS PROVIDES THE LOWEST POSSIBLE RATES FOR THE BENEFITS PROVIDED.

**Second Injury Fund**

South Carolina's Second Injury Fund provides broad coverage and benefits compared to similar funds in many other states. The South Carolina law includes a unique provision, reimbursement for "unknown conditions." This provision could increase the assessment paid by insurers for the Second Injury Fund, a higher percentage of premium (13%) in South Carolina than in any other state for which data is available.

All insurers and self-insured employers pay into the Second Injury Fund, a separate state agency which reimburses them when the impairment caused by an employee's on-the-job injury is substantially greater because of a prior injury or condition sustained by the employee.

Generally, as stated in an IAIABC standard, the intent in establishing second or subsequent injury funds has been to encourage the hiring of the handicapped by protecting employers from excess liability when a handicapped worker is injured. For example, an employer might consider hiring a worker with one leg if he knows that he would only have to pay for a portion of the disability caused by any future accident.

A broad second injury law covers prior conditions, not just prior injuries. The South Carolina law covers a wide range of handicaps including such conditions as epilepsy, diabetes, cardiac disease, and arthritis. Although the coverage is patterned after the model legislation proposed by the Council of State Governments, it extends beyond the recommended coverage.

The model legislation suggests that in order to be reimbursed, the employer must establish that he knew of the employee's impairment at the time of hiring. The South Carolina law has this "knowledge" requirement, but also allows an exception--reimbursement for "unknown conditions"--when the employer did not have knowledge of the prior condition either because the "...existence of such

condition was concealed by the employee or was unknown to the employee."

The "unknown condition" provision is unique to the South Carolina law. Claims under the "unknown condition" exception have accounted for more than 50% of the funds disbursed by the Second Injury Fund on cases closed since FY 82-83. In FY 85-86, the Second Injury Fund disbursed a total of more than $17 million.

The unknown condition provision was included in the law because of concern for employers who had injured employees whose injury was made more severe due to previously unknown conditions, such as heart disease. However, coverage for unknown conditions is not directly related to encouraging the hiring of the handicapped. If an employee's condition is unknown, an employer would assume that he is hiring a healthy worker.

Coverage for unknown conditions allows insurers to share the risk of unknown handicaps in the population and may raise the costs of the workers' compensation system in South Carolina. Insurers might accept questionable cases they would otherwise deny if they know that the Second Injury Fund will pay. Also, once the Second Injury Fund has accepted a case, there is little incentive for an insurer to hold settlement costs down.

**RECOMMENDATION**

86. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY CONSIDER WHETHER §42-9-400(c) AND §42-9-410(d) OF THE SOUTH CAROLINA CODE OF LAWS SHOULD BE AMENDED TO ELIMINATE SECOND INJURY FUND COVERAGE OF UNKNOWN AND CONCEALED CONDITIONS.

**Workers' Compensation Tax**

The South Carolina workers' compensation tax of 4.5%, paid by insurers on premiums and self-insured employers on the actual cost of workers' compensation operation, is a higher tax percentage than in other states that have such a tax. Premium taxes for workers' compensation in 42 states for which data is available, average approximately 2.6%.

The workers' compensation tax is deposited in the General Fund. Approximately 24% of the tax revenue collected is appropriated to the Workers' Compensation Commission to administer the law. The tax collected in FY 86-87 was over $14.7 million. The budget of the Workers' Compensation Commission was approximately $3.5 million, and $11.2 million remained in the state's General Fund.

The premium tax has been 4.5% since 1937. Its use was restricted to Industrial Commission expenses and payment of workers' compensation awards to state employees until 1947 when the law was changed to allow it to be spent "for any expenses authorized by law."

The Council of State Governments' model legislation recommends the use of a premium tax to provide for the expense of administering the law. The model legislation suggests a tax of 2%, or a figure chosen to conform to the general premium tax level of the state. In South Carolina the premium tax is .75% for life insurance and 1.25% for all other types of insurance except workers' compensation.

Because of the tax rate, workers' compensation premiums in South Carolina are higher than necessary to administer the Act. In effect, insurers, employers, and consumers are paying a "hidden" tax to the state, which amounted to $11.2 million in FY 86-87. This could have a detrimental effect on economic development.

**RECOMMENDATION**

87. IT IS THE AUDIT COUNCIL'S RECOMMENDATION THAT THE GENERAL ASSEMBLY EVALUATE

CURRENT PROVISIONS OF THE SOUTH CAROLINA WORKERS' COMPENSATION PREMIUM TAX TO ENSURE THEY ARE IN ACCORD WITH LEGISLATIVE INTENT.

# APPENDICES

APPENDIX A

# The South Carolina Industrial Commission




**ADMINISTERING THE WORKERS' COMPENSATION ACT**
**MIDDLEBURG OFFICE PARK**
**1800 ST. JULIAN PLACE**

Columbia, S.C. 29204




August 22, 1984

The Honorable George L. Schroeder
Director
Legislative Audit Council
620 Bankers Trust Towers
Columbia, South Carolina 29201

Dear Mr. Schroeder:

The General Assembly of South Carolina in its deliberations during the 1984 session expressed a serious interest in the South Carolina Industrial Commission, its records on workers' compensation claims and its functions in administering the South Carolina Workers' Compensation Act. The extent of this interest was expressed overwhelmingly by the House of Representatives in the passage of legislation giving subpoena powers to the Committee as assembled by Senator John D. Drummond and the deliberations of that legislation in the State Senate. However, no definitive final action was taken by the General Assembly but the reports by the news media as the basis for the General Assembly's interest created widespread public interest in the Industrial Commission's functions and its capabilities to administer the Workers' Compensation Law fairly and justly.

The Industrial Commission has made available its records to the Drummond Committee and to the media as requested and in accordance with the South Carolina Supreme Court decision in Blue Cross Blue Shield of South Carolina vs. South Carolina Industrial Commission, 262 S.E. 2d 35 (1-16-80); and in keeping with that Court decision, as we understand it, records of the uncontested cases have not been disclosed.

The Industrial Commission by appropriate resolution transmitted to the General Assembly on May 23, 1984 outlined its position concerning disclosure of records and offered full cooperation to the General Assembly in all matters. There is a continuing interest that all records of the Industrial Commission be made available appropriately to the General Assembly. The Industrial Commission at a meeting last week has authorized and directed me to do what is necessary to get the Legislative Audit Council to perform as soon as possible a complete study, review and evaluation of the Industrial Commission, its functions and to have access to any and all records on claims processed by the Commission and any other matters deemed appropriate.

We believe that the Legislative Audit Council being an official arm of the General Assembly possessed of subpoena powers could not be denied access to any records maintained by the Commission.

We would appreciate your early response to this request and advise accordingly what we may do to assist your good offices in initiating the requested study and audit.

Very cordially yours,

SOUTH CAROLINA INDUSTRIAL COMMISSION

James J. Reid

James J. Reid, Chairman

JJR:scf

JOHN DRUMMOND
SENATOR, GREENWOOD AND McCORMICK COUNTIES
SENATORIAL DISTRICT NO. 3

HOME ADDRESS:
BOX 127
NINETY SIX, S. C. 29666

BUSINESS ADDRESS:
BOX 748
GREENWOOD, S. C. 29646

THE SENATE OF SOUTH CAROLINA

COMMITTEES:
LABOR, COMMERCE AND INDUSTRY, Chairman
ETHICS
FINANCE
FISH, GAME AND FORESTRY
RULES
TRANSPORTATION

SENATE ADDRESS:
SUITE 303, GRESSETTE SENATE OFFICE BLDG.
COLUMBIA, S. C. 29202
PHONE: 758-3804

August 27, 1984

Mr. George L. Schroeder
Director
Legislative Audit Council
620 Bankers Trust Tower
Columbia, South Carolina 29201

Dear George:

At the August 22 meeting of a special legislative committee studying problems within the workers compensation program, the Chairman of the Industrial Commission announced the following action by the Commission:

"(The Commission) authorized and directed the Chairman of the Commission to do what is necessary to get the Legislative Audit Council to as early as possible make a full audit, study, review and evaluation of the Industrial Commission, its functions and to grant full access to all records of the Commission to the Audit Council as the official arm of the Legislature possessing subpoena powers; and that the findings and recommendations of the Audit Council be made available to members of the General Assembly and to the public."

Section 2-15-60 of the S. C. Code provides that requests for investigations or studies by the Legislative Audit Council must come from a member of the General Assembly. It is therefore the purpose of this letter that I, as a State Senator, do hereby convey to you my formal request of the Audit Council that the above-referenced audit be performed as quickly as may be scheduled by you and the Council. I join Chairman Reid in requesting that the work be performed as early as possible, and I would appreciate your assigning to this request the highest possible priority.

It is also my request that at your earliest convenience, we meet to discuss the specific issues to be addressed in the review of the Industrial Commission. I support Chairman Reid's request for a

thorough audit of the Commission, but it would seem helpful to all concerned for there to be a clear understanding of the components of such a study, as well as the time to be required and the projected completion date.

Thank you for your consideration of this request. I look forward to hearing from you, and I hope this is a matter which you will be able to address expeditiously.

Sincerely,

John Drummond
Senator

JD:kc

JAMES R. BROWN, DIRECTOR
RESEARCH AND ADMINISTRATION
GENERAL COMMITTEE
ETHICS COMMITTEE
CORRECTIONS AND PENOLOGY COMMITTEE


GRESSETTE SENATE OFFICE BUILDING
POST OFFICE BOX 142
COLUMBIA, S. C. 29202

September 17, 1984

Mr. George Schroeder
Director
Legislatve Audit Council
620 Bankers Trust Tower
Columbia, South Carolina 29201

Dear George:

This is pursuant to my letter of August 22 in which I formally requested an audit of the S. C. Industrial Commission.

Subsequently, I have received copy of correspondence from the Attorney General's Office to Commissioner James J. Reid, Chairman of the Industrial Commission, which seems to raise questions about the access which may be accorded to your staff in the conduct of the audit. My request was based on the good faith assumption contained in Chairman Reid's statement of August 22, that the Industrial Commission would "grant full access to all records of the Commission to the Audit Council..."

Inasmuch as there now seems to be yet another potential obstacle to gaining reasonable access to Industrial Commission records, I feel compelled to modify my earlier request to you so that it reflects my absolute insistence on full access to files as a condition of my requested Audit Council review. Otherwise, I feel that your best efforts would produce only partial results, and my interests and concerns would once again be thwarted.

Please convey my concerns to your Council in the hope that they will understand my hesitation to proceed without satisfactory guarantees of proper access to information.

As in my earlier letter, I hope to have the opportunity to talk directly with you concerning the scope and areas of concentration of your audit. Inasmuch as a great deal of the interest and attention of the ad hoc committee I formed have focused on the State Workers Compensation Fund, I would hope that your work could reflect that kind of priority without unduly weakening other aspects of your study.

Thank you for your assistance.

Sincerely,

John Drummond
Senator

JD:dcr

The House of Representatives
STATE OF SOUTH CAROLINA
STATE HOUSE
P. O. BOX 11867
Columbia 29211

RAMON SCHWARTZ, JR.
SPEAKER OF THE HOUSE

HOME ADDRESS
LAW RANGE
SUMTER, S.C.
29150

November 30, 1984

MR GEORGE L SCHROEDER
DIRECTOR
LEGISLATIVE AUDIT COUNCIL
620 BANKERS TRUST TOWER
COLUMBIA SC 29201

Dear George:

I understand that the Industrial Commission has requested the Legislative Audit Council to conduct a full audit of the Industrial Commission.

I urge you to act promptly on this request as I feel that an audit would help clear the air and restore the confidence of the public in the commission.

Sincerely,

Ramon

Ramon Schwartz, Jr.

sm

## APPENDIX B

## GLOSSARY

**average weekly wage (aww)** - average weekly earnings of the injured employee in the employment in which he was working at the time of the injury during the period of 52 weeks immediately preceding the date of the injury. Used to compute amount of weekly compensation benefit.

**carrier** - any company, person, or fund authorized to insure under the workers' compensation law.

**casual worker** - an employee whose work is not permanent or regular.

**claim** - request for payment of money or for necessary services in accordance with the workers' compensation law, based upon the allegation of the occurrence of a work injury.

**claimant** - person who asserts a right to receive benefits under the provisions of workers' compensation law.

**clincher** - negotiated settlement agreed to by the injured employee and the employer where the claimant waives his right to additional benefits, if his condition were to worsen, and usually receives the settlement amount in a lump sum.

**compensable case** - a case of injury by accident arising out of, and in the course of, employment which qualifies the injured worker for benefits under the workers' compensation law, including compensation for loss of earnings and medical treatment.

**compensation** - money allowance payable to an employee or to his dependents for loss of wages or permanent disability as provided for in the workers' compensation law.

**contested case** - case in which the parties involved are unable to reach an agreement on an aspect(s) of a settlement and a request is made for a hearing before the Workers' Compensation Commission to determine the matter(s) at issue.

**controverted** - contested or disputed; a controverted case is a contested case (see above).

**direct payment** - a method of providing compensation to claimants where the insurer begins payment within a specified period or notifies the employee of refusal to pay, but no agreement or admission of liability is required.

**disability** - incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment.

**disability rating** - a numerical value indicating the incapacity to earn the wages a claimant was receiving at the time of injury taking into consideration such factors as the claimant's impairment rating, occupation, and education.

**disfigurement** - any scar, deformity, or discoloration caused by a job-related accident or by medical treatment as a result of a job-related injury.

**docketed** - case which has been scheduled or placed on the docket to be heard by the Workers' Compensation Commission for adjudication.

**hearing** - formal legal proceeding held before a Workers' Compensation Commissioner to adjudicate contested issues in a workers' compensation case.

**impairment rating** - a numerical value given by a physician indicating the degree of anatomical or functional loss of, or loss of use of, body part(s).

**Industrial Commission** - agency created in 1935 to administer the South Carolina Workers' Compensation laws; name changed in May 1986 to Workers' Compensation Commission.

**informal conference** - a meeting held by the Commission with the claimant, employer/carrier, and/or attorneys in an effort to resolve a dispute or question, clarify issues, or reach a settlement.

**information resource management** - perspective which views all information, whether manual or computerized in form, as an important organizational resource which should be managed as such.

**Insolvency Fund** - fund established in 1982 to ensure payment of awards of workers' compensation benefits which are unpaid because of the insolvency of employers who fail to acquire necessary coverage for employees.

**Insurance Guaranty Association** - A nonprofit, unincorporated legal entity created by the Legislature to handle outstanding claims of insolvent insurers. It covers several kinds of direct insurance including workers' compensation.

**International Association of Industrial Accident Boards and Commissions (IAIABC)** - a professional organization of workers' compensation specialists which develops model rules and regulations, conducts research, and designs educational programs in the field of workers' compensation.

**liability** - economic obligation of employers/insurers to pay benefits to claimants for work-related injury or illness.

**lump sum** - award which authorizes the immediate payment of a single sum in place of a series of smaller periodic benefit payments previously determined to be payable in the future.

**maximum medical improvement (MMI)** - that time in which further medical recovery from, or lasting improvement to, an injury or disease can no longer reasonably be anticipated, based upon reasonable medical probability.

**medical only** - injuries, usually minor, for which only medical benefits are paid; the injured worker does not miss more than seven days from work.

**National Council on Compensation Insurance (NCCI)** - principal national rating organization for workers' compensation insurance. Calculates rates that its member insurers require to meet loss costs, operating and marketing expenses, plus a fair profit.

**occupational disease** - one caused by a hazard recognized as peculiar to a particular trade, process, occupation, or employment as a direct result of continuous exposure to the normal working conditions thereof. An ordinary disease of life may be deemed an occupational disease if there is "constant exposure" peculiar to the occupation itself which makes the disease a hazard inherent in such an occupation.

**permanent partial disability** - disability where the work injury results in a permanent impairment which is not totally disabling.

**permanent total disability** - the loss of, or the permanent loss of use of, any body part or function which renders the person unable to work - when the incapacity for work resulting from an injury is total.

**premium** - dollar amount paid for a contract of insurance.

**rate** - price per unit of insurance. Rate is multiplied by participant's payroll to determine the premium.

**reserves** - dollar amount set aside to meet future claims liabilities.

**Second Injury Fund** - agency established in 1974 to administer the Fund which reimburses employers when an employee who has a permanent physical impairment incurs a subsequent disability from injury by accident arising out of, and in the course of, his employment, and the resulting disability exceeds the amount which would have resulted from the subsequent injury alone.

**self-insured** - employers who do not purchase workers' compensation insurance, but provide proof of financial ability to pay directly compensation due under workers' compensation law. Two or more employers in businesses of a similar nature may enter into agreements to pool liabilities for the purpose of qualifying as self-insurers.

**specific excess insurance** - coverage which protects self-insurers against catastrophic losses. The insurance covers in excess of the deductible amount retained by the self-insurer for a specific accident.

**State Workers' Compensation Fund (State Fund)** - agency established in 1974 to act as the workers' compensation insurance carrier for state employees and employees of other governmental entities.

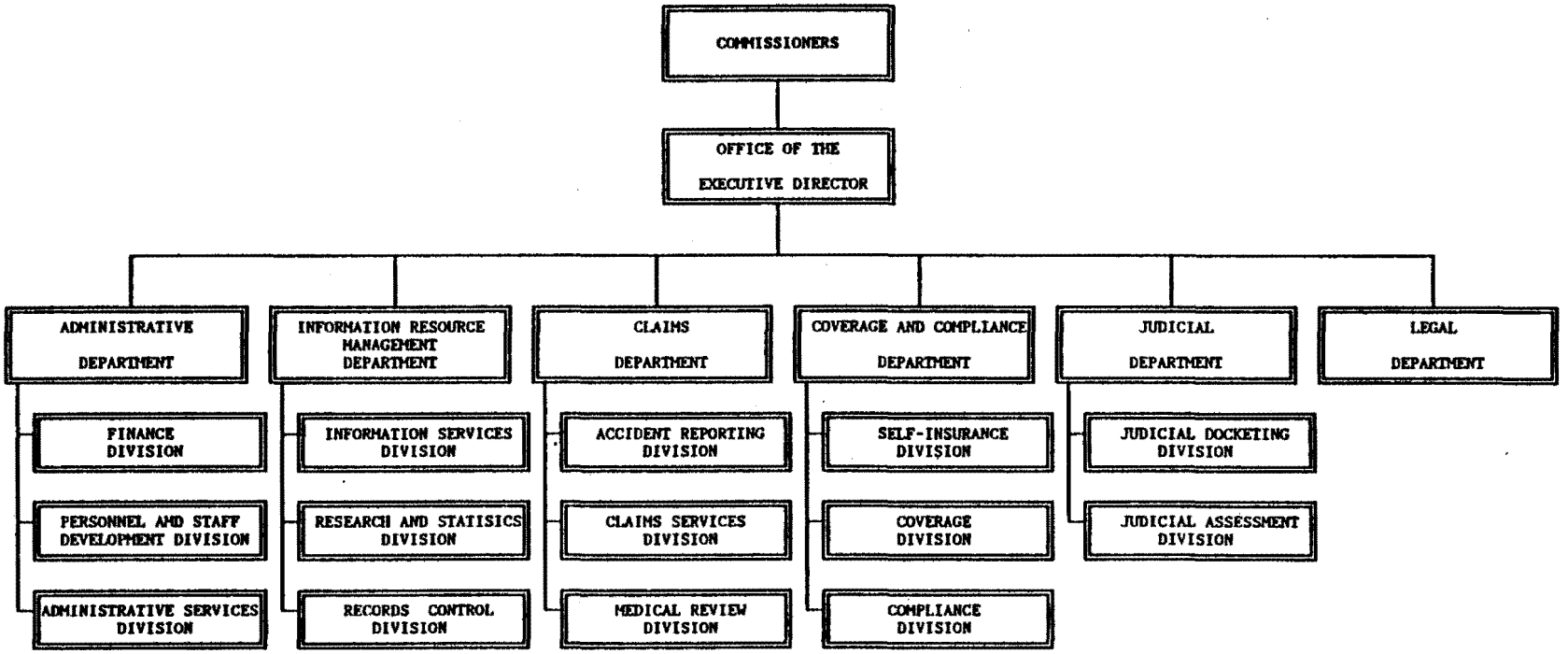
**temporary total disability** - disability where the work injury causes total disability for a temporary period, during which the injured worker receives a weekly benefit amount based on preinjury earnings, 66.67% of his average weekly wages.

**viewing** - a type of informal conference in which an injured or disfigured claimant is "viewed" in order to determine an award amount.

**Workers' Compensation Commission** - agency (South Carolina Industrial Commission until May 1986) responsible for administration and enforcement of the South Carolina Workers' Compensation laws.

## APPENDIX C

## SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

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Total FTE's: 82.48.

Source: Workers' Compensation Commission.

## APPENDIX D

## SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

## ACTUAL REVENUES AND EXPENDITURES

## FY 82-83 THROUGH FY 86-87

| Revenues | FY 82-83 | FY 83-84 | FY 84-85 | FY 85-86 | FY 86-87 |
|---|---|---|---|---|---|
| State General Fund | $1,942,183 | $2,359,016 | $2,698,165 | $3,429,018 | $3,362,256 |
| Federal Funds | 16 | - | - | - | - |
| Other Funds | 140,434 | 115,892 | 74,985 | 102,447 | 184,397 |
| TOTAL | $2,082,633 | $2,474,908 | $2,773,150 | $3,531,465 | $3,546,653 |
| **Revenues Credited to General Fund** | | | | | |
| Taxes/Fees on Self-Insurers | $ 917,117 | $1,039,590 | $1,312,710 | $1,510,292 | $1,774,160 |
| Sale of Publications | - | - | - | 19,387 | 12,909 |
| Sale of Office Equipment | - | - | 288 | 38 | 123 |
| TOTAL | $ 917,117 | $1,039,590 | $1,312,998 | $1,529,717 | $1,787,192 |
| **Expenditures** | | | | | |
| Administration | $ 394,299 | $ 794,397 | $ 965,560 | $ 879,263 | $ 916,396 |
| Judicial | 903,454 | 949,474 | 1,008,458 | 1,148,514 | 1,231,695 |
| Operations/Administration | 557,718 | 475,350 | 509,352 | 980,213 | 1,032,486 |
| Employee Benefits | 227,162 | 255,687 | 289,780 | 334,683 | 366,076 |
| Nonrecurring Appropriations | - | - | - | 188,792 | - |
| TOTAL | $2,082,633 | $2,474,908 | $2,773,150 | $3,531,465 | $3,546,653 |
| TOTAL Personnel | 68.48 | 69.48 | 72.48 | 81.48 | 82.48 |

Source: South Carolina Budget Documents, Budget and Control Board.

Note: Information Services was moved from Administration to Operations/Administration in FY 85-86.
The Medical Division was moved from Operations/Administration to Judicial in FY 85-86.

## APPENDIX E

### TABLE 2

### COMPARATIVE WORKERS' COMPENSATION COSTS

### (DOLLARS PER EMPLOYEE PER WEEK)

| Jurisdiction | 1972 | 1975 | 1978 | 1984 | Rank 01-01-84 |
|---|---|---|---|---|---|
| Hawaii | $1.31 | $2.23 | $3.96 | $12.13 | 1 |
| Alaska | 1.63 | 4.13 | 4.88 | 10.75 | 2 |
| Oregon | 2.27 | 3.87 | 6.29 | 8.18 | 3 |
| DC | 1.22 | 2.85 | 8.20 | 7.55 | 4 |
| California | 1.76 | 2.75 | 4.82 | 7.11 | 5 |
| Michigan | 1.49 | 2.48 | 4.37 | 6.83 | 6 |
| Montana | 1.33 | 2.70 | 2.80 | 6.34 | 7 |
| West Virginia | .56 | 1.07 | 1.23 | 6.33 | 8 |
| Connecticut | 1.01 | 1.47 | 2.77 | 5.79 | 9 |
| Maryland | 1.15 | 1.75 | 2.53 | 5.76 | 10 |
| New Mexico | .96 | 1.59 | 2.48 | 5.72 | 11 |
| Ohio | 1.35 | 2.08 | 3.35 | 5.45 | 12 |
| Texas | - | - | 3.29 | 5.17 | 13 |
| Florida | - | - | 4.79 | 4.89 | 14 |
| Maine | .69 | 1.59 | 2.58 | 4.89 | 14 |
| Minnesota | 1.24 | 2.20 | 3.73 | 4.70 | 16 |
| Massachusetts | 1.57 | 2.04 | 2.76 | 4.64 | 17 |
| Pennsylvania | .55 | 1.37 | 2.38 | 4.51 | 18 |
| Colorado | .97 | 1.20 | 2.55 | 4.43 | 19 |
| Oklahoma | - | 1.67 | 2.65 | 4.38 | 20 |
| Illinois | 1.03 | 1.93 | 3.06 | 4.37 | 21 |
| New Jersey | 1.87 | 2.31 | 3.65 | 4.26 | 22 |
| New Hampshire | .69 | 1.18 | 2.13 | 4.21 | 23 |
| Rhode Island | .99 | 1.43 | 2.39 | 3.97 | 24 |
| Arizona | 2.07 | 3.99 | 5.29 | 3.97 | 24 |
| New York | 1.33 | 1.83 | 3.84 | 3.89 | 26 |
| Idaho | 1.06 | 1.93 | 2.24 | 3.79 | 27 |
| Louisiana | - | - | 2.91 | 3.33 | 28 |
| Delaware | .84 | 1.30 | 2.92 | 3.32 | 29 |
| Arkansas | 1.04 | 1.45 | 2.08 | 3.20 | 30 |
| Wisconsin | .75 | 1.06 | 1.58 | 3.00 | 31 |
| Iowa | .64 | 1.16 | 2.19 | 2.98 | 32 |
| Kentucky | .95 | 1.86 | 2.78 | 2.90 | 33 |
| Alabama | .61 | .94 | 1.54 | 2.72 | 34 |
| **South Carolina** | .70 | .83 | 1.36 | 2.71 | 35 |
| Virginia | .48 | .81 | 1.53 | 2.63 | 36 |
| Georgia | .63 | 1.17 | 1.91 | 2.58 | 37 |
| Vermont | .68 | .96 | 1.65 | 2.57 | 38 |
| Kansas | .77 | 1.25 | 1.66 | 2.56 | 39 |
| Utah | .68 | 1.27 | 1.70 | 2.56 | 39 |
| Nebraska | .78 | 1.43 | 1.48 | 2.53 | 41 |
| Tennessee | .87 | 1.13 | 1.67 | 2.36 | 42 |
| South Dakota | .71 | 1.08 | 1.65 | 2.35 | 43 |
| Mississippi | .86 | 1.26 | 1.46 | 2.34 | 44 |
| Missouri | - | - | 1.20 | 2.24 | 45 |
| North Carolina | .50 | .63 | .90 | 1.62 | 46 |
| Indiana | .58 | .77 | 1.02 | 1.21 | 47 |
| **Average-Nation** | $1.03 | $1.72 | $2.77 | $4.38 | |
| **Average-SE states** | .70 | 1.08 | 2.08 | 2.81 | |
| **South Carolina** | .70 | .83 | 1.36 | 2.71 | |

Source: Interstate Variations in the Employers' Cost of Workers' Compensation, Burton, Hunt, and Krueger, 1985.

## APPENDIX F

## AUDIT COUNCIL OPINION SURVEYS

To assess the opinions of interested parties about the South Carolina workers' compensation program, in 1986 the Audit Council compiled and distributed a series of surveys to: employers; attorneys; insurance companies; and medical professionals.

Surveys were sent to: a sample of the state's 300 largest manufacturers; 47 (27 defense and 20 claimant) attorneys who had represented clients in at least 25 workers' compensation cases closed in each of the years FY 84-85 and FY 85-86; 49 high volume workers' compensation insurance companies; and a sample of medical professionals who receive copies of the Workers' Compensation Commission's medical fee schedule. The table below shows the number surveyed and response rates.

Each survey included multiple choice and open-ended questions. The responses to the multiple choice questions are reproduced on the following pages.

### TABLE 3

### 1986 WORKERS' COMPENSATION COMMISSION INTERESTED PARTY SURVEYS

| Interested Party | # Surveyed | # Returned | Response Rate |
|---|---|---|---|
| Employers | 150 | 95 | 63% |
| Attorneys | 47 | 27 | 57% |
| Insurance Companies | 49 | 33 | 67% |
| Medical Professionals | 71 | 33 | 46% |

# LEGISLATIVE AUDIT COUNCIL

## STATE OF SOUTH CAROLINA

620 NCNB TOWER
COLUMBIA, SOUTH CAROLINA 29201

TELEPHONE
803-734-1320




Dear _____:

At the request of the South Carolina General Assembly, the Legislative Audit Council is reviewing the South Carolina Workers' Compensation Commission and State Workers' Compensation program. In an effort to assess input from interested parties, the Council would like to obtain your ideas and opinions on workers' compensation in this state.

We would appreciate your honest and candid answers to the enclosed questionnaire. Your responses are confidential and it is not necessary to identify yourself. Please return the completed questionnaire by _____, to the South Carolina Legislative Audit Council. A postage-paid envelope has been provided.

If there are any questions or if you wish to make further comments, please contact Cheryl Ridings, Assistant Director, or Jane Thesing, Senior Auditor, at 734-1320. Your remarks will be held in confidence. Thank you for your assistance.

Sincerely,

George L. Schroeder
Director

/mr
Enclosures

## SURVEY OF EMPLOYERS REGARDING WORKERS' COMPENSATION

The following statements express a range of opinions you may have about the South Carolina workers' compensation system. Please circle one response for each statement. You are encouraged to comment on the open-ended questions, or make additional statements, if you desire, on the back of this form.

| % Responding | | |
|---|---|---|
| | 1. | My business purchases workers' compensation insurance from: |
| 70 | a. | An insurance company |
| 26 | b. | Is self-insured |
| 4 | c. | Is group self-insured |
| 0 | d. | Is not insured |
| | 2. | The number of persons employed by my business is: |
| 1 | a. | 1-3 |
| 0 | b. | 4-10 |
| 99 | c. | Over 10 |
| | 3. | Workers' compensation insurance premiums in South Carolina are: |
| 36 | a. | Very high |
| 35 | b. | Somewhat high |
| 16 | c. | Average |
| 1 | d. | Somewhat low |
| 12* | | |
| | 4. | Workers' compensation benefits in South Carolina are: |
| 30 | a. | Very high |
| 32 | b. | Somewhat high |
| 39 | c. | Average |
| 1 | d. | Somewhat low |
| | 5. | The delivery of workers' compensation benefits in South Carolina is: |
| 39 | a. | Timely |
| 39 | b. | Average |
| 18 | c. | Somewhat slow |
| 4 | d. | Very slow |
| | 6. | Awards and decisions of the Workers' Compensation Commissioners are: |
| 93 | a. | Very liberal |
| 7 | b. | Fair |
| 0 | c. | Very conservative |

*No Response

## SURVEY OF ATTORNEYS REGARDING WORKERS' COMPENSATION

The following statements express a range of opinions you may have about the workers' compensation system in South Carolina. Please circle only one response per question. You may elaborate in the open-ended questions at the end of the survey. Please feel free to make additional statements, if you desire, on the back of this form.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| DEFINITELY AGREE | INCLINED TO AGREE | UNDECIDED | INCLINED TO DISAGREE | DEFINITELY DISAGREE |

| % Responding | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | N/R* | |
| 30 | 44 | 4 | 15 | 4 | 4 | 1. The South Carolina Workers' Compensation Commission system delivers benefits with a minimum of delay and litigation. |
| 7 | 22 | 11 | 19 | 41 | - | 2. Workers are sufficiently informed by their employers of their rights. |
| 30 | 30 | 0 | 19 | 22 | - | 3. Attorney fees are equitably regulated by the Workers' Compensation Commission. |
| 33 | 19 | 4 | 15 | 30 | - | 4. Certain attorneys receive preferential treatment from the Workers' Compensation Commission. |
| 33 | 44 | 4 | 7 | 11 | - | 5. Statutes protect the rights of minors adequately in workers' compensation cases. |
| 15 | 26 | 0 | 22 | 37 | - | 6. The South Carolina workers' compensation system encourages litigation. |
| 44 | 48 | 4 | 4 | 0 | - | 7. Appeals are handled expeditiously. |
| 26 | 63 | 11 | 0 | 0 | - | 8. The Workers' Compensation Commission handles claims in a timely manner. |
| 30 | 11 | 4 | 22 | 33 | - | 9. Individual commissioners have too much discretionary power in determining cases. |
| 33 | 19 | 4 | 15 | 30 | - | 10. The Workers' Compensation Commission should establish regional hearing sites instead of hearing cases in the county where the accident occurred. |

*No Response

## WORKERS' COMPENSATION INSURANCE SURVEY

The following express a range of opinions you may have about the workers' compensation system in South Carolina. Please circle only one response per question. You may elaborate in the open-ended questions at the end of the survey.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| DEFINITELY AGREE | INCLINED TO AGREE | UNDECIDED | INCLINED TO DISAGREE | DEFINITELY DISAGREE |

| % Responding | | | | | |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | |
| 12 | 18 | 12 | 27 | 30 | 1. The Workers' Compensation Commission is a well-managed agency. |
| 3 | 6 | 3 | 21 | 67 | 2. The Commission is fair and consistent in its handling of contested cases. |
| 3 | 33 | 33 | 15 | 15 | 3. The Commission imposes fines and penalties in a consistent manner and as required by law and regulations. |
| 12 | 21 | 9 | 36 | 21 | 4. In general, benefits paid to injured workers are adequate and fair. |
| 6 | 24 | 42 | 15 | 12 | 5. Premiums paid by employers are appropriate for the benefits received under workers' compensation in South Carolina. |
| 70 | 27 | 0 | 3 | 0 | 6. This company checks all medical bills and sends those charging an excessive amount to the Commission for review (if not, briefly explain procedure). |

## MEDICAL PROFESSIONAL SURVEY ON WORKERS' COMPENSATION

The following statements express a range of opinions you may have about the workers' compensation system in South Carolina. Please circle only one response for each statement. You are encouraged to comment on the open-ended questions, or make additional statements, if you desire, on the back of this form.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| DEFINITELY AGREE | INCLINED TO AGREE | UNDECIDED | INCLINED TO DISAGREE | DEFINITELY DISAGREE |

| % Responding | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | N/R* | | |
| 30 | 30 | 9 | 9 | 12 | 9 | 1. | I always follow objective AMA criteria for determining impairment ratings. |
| 70 | 15 | 0 | 3 | 9 | 3 | 2. | I always use the Workers' Compensation Commission's Schedule of Fees in billing patients. |
| 36 | 27 | 9 | 15 | 9 | 3 | 3. | The Workers' Compensation Commission's Schedule of Fees is fair and adequate. |
| 15 | 39 | 3 | 18 | 15 | 9 | 4. | Payments from workers' compensation patients are as timely as payments from other patients. |
| 33 | 24 | 18 | 15 | 6 | 3 | 5. | Medical reports would be as adequate as depositions for use as evidence in workers' compensation hearings. |
| 52 | 12 | 3 | 15 | 12 | 6 | 6. | Workers' compensation patients should be allowed to choose their own treating physicians. |

*No Response

APPENDIX G

State of South Carolina

1612 Marion Street
P.O. Box 1715
Columbia, S.C. 29202-1715

(803) 737-570(

# Workers' Compensation Commission

March 8, 1988



Mr. George L. Schroeder
Director
Legislative Audit Council
620 NCNB Tower
Columbia, South Carolina 29201

Dear Mr. Schroeder:

Thank you for the opportunity to review and respond to the findings and recommendations of the Legislative Audit Council. As the Council observed in the report, the Commission has worked very diligently during the past eighteen months to improve the administration and management of the Workers' Compensation Commission. There is much which still must be accomplished, and the Commission intends to use the report of the Legislative Audit Council as a blueprint for the future development and improvement of South Carolina's workers' compensation system.

On August 22, 1984, Commissioner James J. Reid, on behalf of a unanimous Commission, requested that a complete and comprehensive program audit be initiated. During the extended period of research and inquiry conducted by the Council, the commissioners and staff of the Commission cooperated fully and completely with all aspects of the review.

In the three and one-half years since the audit was requested, there have been many significant changes at the Commission. Only two of the commissioners serving at the time of Chairman Reid's request are still on the Commission. Organizational changes have been made, a new executive director has been appointed, and the Commission has moved aggressively, within the limits of legal restrictions and constrained resources, to initiate changes and improvements in areas identified by the new management.

The Commission is particularly pleased with the conclusions reached by the Council in "Part III - Cost Issues." The cost of workers' compensation premiums has been a subject of constant

debate for the last two years. In this report, the LAC establishes that "South Carolina's costs have been consistently lower than both the national average and the average of ten southeastern states." Moreover, the Council presents an array of factors that must be considered when true costs are being determined.

Specific responses to some of the Council's discussions and recommendations are included as an attachment to this letter. Because of the limitations placed on the length of our response, the Commission's text focuses on the most pertinent issues raised by the Council. The Commission acknowledges the comments and recommendations of the Council and will begin work immediately to address, as practically as possible given current human and fiscal resources, areas for improved efficiency.

As a matter of orientation to the responses that follow, the Commission makes several observations. First, the workers' compensation system in South Carolina is very closely controlled by legislation. From the way the Commission is organized to the value of a toe, Title 42 of the Code of Laws of South Carolina prescribes the Commission's responsibilities and operations in very finite detail. Although the Council tried to separate the administrative issues from the legislative issues, the two are so closely interrelated and entwined that many of the proposed administrative recommendations can only be accomplished through statutory changes.

A second point that must be considered is that the Commission cannot be defined within the pure context of either an administrative agency or a judicial agency. In a sense, the Commission is a quasi-judicial agency whose operations should not be evaluated or assessed according to strict judicial or administrative standards. While guidelines do promote consistent and uniform decision-making in a majority of cases, they should not be an exclusive substitute for a commissioner's discretion which is based on experience, personal observation, specific knowledge, and a duty to render fair and impartial decisions to fit the particular circumstances.

Third, South Carolina's workers' compensation system is based on benefits for specific disabilities and not wages lost. During the course of the Council's discussion, it appears as if some of the Council's findings exist because the Council believes that the Commission has not applied the wage loss concept in establishing benefits. In many instances, it appears as if the Council has applied a very narrow interpretation of the statutes without giving sufficient consideration to case law or contextual statutory references.

Finally, the Commission commends the Council on the cooperation and professionalism of the auditors who spent so many months working with the Commission's staff. We found them to be a courteous, respectful, and hard-working group of individuals.

The Commission pledges that it will continue to work for the improvement of the system in an open and honest manner realizing that any real progress must be achieved in cooperation with the General Assembly which is responsible for passing enabling legislation and providing adequate resources sufficient to manage a very complex administrative and judicial agency.

Yours very truly,

Milton Kimpson

Milton Kimpson
Chairman

MK/dd

Attachment

The Response of the South Carolina Workers' Compensation Commission
to the findings and recommendations of the
South Carolina Legislative Audit Council
as reported in
A Program Review of the South Carolina Workers' Compensation Commission

Major Recommendations - pages 3-4

1. The Commission is committed to fairly and objectively applying the laws of this state as promulgated by the General Assembly. During the course of the Legislature's debate and deliberations, the Commission will continue to cooperate fully and completely.

2. It is the intent of the Commission to apply its energies and resources to improving the administration of the workers' compensation program in South Carolina. All efforts in this area will be done with complete openness and in close cooperation and consultation with the various interested parties. Reports will be made as required by the General Assembly.

Recommendation - page 10

3. The method and manner in which the commissioners should be organized and disputed workers' compensation cases adjudicated is a matter of legislative prerogative. The Commission is willing to offer advice and comment on any organization plan proposed for legislative consideration.

Recommendation - page 14

6. The Commission agrees that the efficient and effective administration of the agency is unnecessarily restricted by the organizational specificities prescribed by legislation. Proposed amendments addressing this problem will be discussed with the General Assembly during the 1988 session.

LAC Discussions on Medical Evidence - pages 15-17

Clincher agreements (voluntary settlements) are a valid and legally accepted method of settling questionable cases in controversy. The use of such agreements is recognized in Section 42-9-390 and in such prior court decisions as Atkins v. Charleston Shipbuilding and Drydock Company, 206 S.C. 63, 33 S.E.2d 46 (1945). Disability and impairment ratings notwithstanding, the parties to a clincher agreement voluntarily settle all disputed issues - which may or may not include the extent of the disabling injury - for a specific amount of money in exchange for a full and final release for all present and future liabilities.

Permanent impairment, according to the American Medical Association, is a purely medical condition and is defined as "any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved, which abnormality or loss the physician considers stable or non-progressive at the time evaluation is made." Physical impairment, i.e. diminished range of motion, strength, flexibility, etc., is always a basic consideration in the evaluation of permanent disability. Although the South Carolina Code of Laws does not make specific reference to the AMA Guide, the commissioners routinely refer to it, and the Guide forms the basis of Rule 67-35.

Permanent disability is not a pure medical condition. The Commission determines the claimant's disability in terms of future ability to engage in gainful activity as is affected by such diverse factors as age, sex, education, employment history, and economic and social

environment in addition to the medical factor: permanent impairment.

LAC Discussions on Disfigurement - pages 18-19

The statute and rule defining disfigurement, although interpreted many times by court rulings, remains very ambiguous and a complete matter of a commissioner's discretion not to exceed a maximum award of fifty weeks compensation.

The Commission believes that Section 42-9-30(21) should be quoted in its entirety because the final words of the section make serious burn scars and keloid scars compensable anywhere on the body.

Recommendation - page 20

8. The Commission does award compensation for disfigurement according to state law; however, the Commission will review its practice to determine if modifications are warranted.

LAC Discussion on Uncontested Permanent Partial Claims - pages 20-22

As long as Title 42 prescribes a system of compensation based on the disability of injured body parts and organs, the commissioners, or a designated representative, must "view" the extent of the disability to make an award in cases where an employee is not represented by an attorney. Even if a claimant does not formally contest a proposed settlement offer from an insurance carrier, it is the responsibility of the Commission to assess the medical disability (as opposed to the physician's impairment rating) in order to protect the claimant's rights and benefits under the law. If the claimant is represented by an attorney, he and his attorney may settle a permanent partial disability claim with the employer's insurance carrier, upon the approval of the Commission, by executing a Supplemental Memorandum of Agreement (Form 16) or upon the Commission's approval of a clincher agreement. If the Commission did not attempt to resolve unrepresented claims through these viewings (informal conferences), then a formal APA hearing would be needed in order to bring about a proper determination.

The Commission is required to determine disability in each case, and under South Carolina law, it would not be in the best interest of the claimant to accept the actual physician's impairment rating as a full and final settlement of an injury. Conferences are held with unrepresented claimants to ensure that each claimant is informed of his full rights and benefits under the Workers' Compensation Act. It would take an act of the legislature to allow the Commission to administratively approve uncontested claims for unrepresented claimants based strictly on impairment ratings.

Recommendation - page 23

10. The Workers' Compensation Commission will determine awards in whatever manner prescribed by the legislature.

Recommendation - page 24

12. Since January 1987, the Commission's staff attorney has maintained a notebook of all appeals and the resulting orders. Because of the tremendous demands on the attorney's time, the current book has not been indexed and appeals prior to 1987 have not been collected. The West Publishing Company of St. Paul, Minnesota is very interested in creating a computer record and a cross-referencing index of all Commission appellant decisions for the last five years. An agreement with West may be the quickest and least expensive method of completing a manual.

Recommendation - page 26

13. The decision to restrict lump-sum settlements is a legislative one, since the language in the enabling statute (Section 42-9-301) has been written to allow for the broad application of this provision. Act 42, Section 5, which was effective June 10, 1983, deleted the former restrictive language which limited lump-sum payments to "unusual cases." In addition, by virtue of the same Act, the General Assembly placed the burden of proof as to the abuse of discretion in such findings on the employer. The Commission does not feel it can place strict administrative criteria on a legislative process meant to be totally discretionary and open to broad application without some further legislative guidance.

Recommendation - page 28

14. Both South Carolina statutory law, Section 42-9-390, and South Carolina case law recognize the legal validity and general efficacy of voluntary settlements as a means of resolving questionable disputes. In such instances where the parties enter into an agreement, there are often contested issues other than the degree of disability and future medical benefits. As with lump-sum settlements, the legislature has written this particular section in broad terms, stating clearly that "Nothing contained in this chapter shall be construed so as to prevent settlements made by and between an employee and employer ...." The Commission is extremely reluctant to impose additional administrative restrictions on a statute without specific direction from the General Assembly.

LAC Discussion on Commission Enforcement - pages 31-33

The Commission requires that the First Report of Injury and physicians' medical reports be submitted as required by law. Unfortunately, the Commission does not have sufficient human resources to enforce this requirement in 100% of the case violations. Even with its limited resources, the Commission levied fines for more than 2,500 violations during FY 1986-87.

The Commission does not write drafts in payment of compensation claims. Drafts are written by insurance companies, and it is impossible for the Commission to monitor the payees of every check on an *a priori* basis. Action in this matter can only be taken after the fact when the Commission has notice. The incident involving a commissioner ordering the delivery of a check to an attorney is an isolated one. All commissioners are aware and observe Regulation 67-9.

Although a Form 20 is required to substantiate an individual's average weekly wage in many cases, testimony in lieu of a Form 20 may be taken at a formal hearing to establish the claimant's average weekly wage. In many other instances - Agreement as to Compensation (Form 15), Supplemental Agreement (Form 16), and Receipt for Compensation (Form 17) - both parties actually stipulate to the correct compensation rate.

Recommendation - page 35

18. The Workers' Compensation Commission intends to revise and present all of its existing and proposed regulations according to the provisions of the Administrative Procedures Act, although it is the contention of the Workers' Compensation Commission that those rules and regulations in effect prior to the adoption of the Administrative Procedures Act are valid unless substantially amended to affect the public interest.

Recommendations - pages 43-44

20. Regulating attorney fees is a very volatile task which is best left to the legislature in the form of statutory provisions as effected by nine of the twelve states surveyed by the LAC.

Section 42-15-90 requires the Commission to approve fees for attorneys. There is no legislative direction with regard to establishing minimum and maximum legal fees. The Commission does not feel that it promulgated a new regulation when it revised its fee petition in March, 1987. Fees are still approved on an individual basis; however, in revising the petition, the Commission attempted to explain to the attorneys the general criteria against which attorney fees would be reviewed.

21. The Commission wholeheartedly agrees that the legislative committee should seriously consider establishing guidelines for attorney fees in statute in order to relieve the Commission of the undue burden and pressure placed upon it to control such fees through regulations.

22. The Workers' Compensation Commission acknowledges the benefit of collecting statistical information on claimant attorney fees; however, the Commission needs additional statistical personnel and expanded computer capacity in order to accomplish this.

23. The Workers' Compensation Commission agrees that approval of claimant attorney fees should be done administratively to relieve the commissioners of this burden and to make the approvals more consistent and uniform. A position to administratively approve attorney fees has been requested in the Commission's budget request for FY 1988-89.

24. The Commission has reviewed the legal requirements of Section 42-15-90 relating to the approval of defense attorney fees. It is the belief of the Commission that since the statute refers to "attorneys" without making a distinction between plaintiff and defense attorneys that it is required to approve all attorney fees, including defense attorneys.

LAC Discussion on Control of Medical Cost - pages 44-45

The conversion factor used by the Commission's Fee Schedule for Surgeons and Physicians has not been increased since November, 1985. This means that fees for physicians and surgeons have not increased during a period of twenty-six months. The Commission does not dispute the fact that the cost of medical care as a proportion of all funds expended has increased. The Commission would like to point out that the increase could be the result of increased testing and treatment provided to the injured workers. Because of advances in medical technology, the injured worker is now getting more extensive and complete care than previously available.

Recommendation - pages 47-48

27. At the present time, insurance carriers represent the first level of cost control of medical and hospital fees, especially since the carriers are responsible for selecting and approving providers. Because the Commission does not have the resources to approve every physician and hospital bill, the compromise is to review those bills which the carriers believe exceed the published fee schedules. During FY 1987, a total of 36,333 bills were reviewed by the Medical Division which consists of a supervisor and two staff persons. More than 44% of those bills were approved for reduced payment. The FY 1988-89 budget request identifies the need for an additional employee in the Medical Services Division. The Commission feels that with the addition of this employee and necessary improvements to the electronic data processing system the Medical Division can accomplish the recommendations outlined by the Council.

Recommendation - pages 52-53

33A. To aggressively pursue uninsureds and to inspect business locations for compliance with the posting of notices, the Commission needs additional staff to supplement its one compliance officer. The budget request for FY 1988-89 identifies two compliance officers as the Commission's second priority.

Recommendation - page 54

35. The Workers' Compensation Commission has continually placed a high priority on obtaining and allocating resources for the development of an adequate automated information system. Not only has a majority of the earned revenue collected by this agency been allocated to the development of information resources, the first priority in the FY 1988-89 budget request is for an additional systems analyst. A recent reorganization was aimed directly at concentrating the limited resources in this critical area in an information resource management department.

Recommendation - page 56

36. The Commission realizes that its information system is insufficient. An extensive study was initiated by an outside consultant to identify the system's current capacity and to make recommendations for future development. Advancement in this area will take an additional financial commitment by the General Assembly in both equipment and personnel. There has not been a budget request submitted by the Commission since 1983 that did not ask for additional money in this area. The Commission is anxious to develop standard statistical programs once the appropriate hardware and software are in place.

Recommendation - page 57

39. The Commission is assaulted with thousands of data elements each day. It realizes that the intelligent capturing and use of this information would increase its ability to manage the agency in a more cost effective and efficient manner. Moreover, adequate statistical information could provide an indication of the performance of the system as a whole. In order to expand the Commission's ability to capture the available data, improvements must be made in the Commission's information data systems and additional staff must be employed to enter the required information into the data system.

Recommendations - page 59

40 and 41. It is the Commission's belief that at the time of purchase it complied with state regulations concerning the procurement of services. A complete review of the Commission's authority will be conducted with the Materials Management Office of the Budget and Control Board to ensure that all state purchasing laws are being complied with.

LAC Discussion on Public Information - pages 61-64

In the area of public information, the Commission has simply lacked the resources needed to pursue an effective program. At the present time, the executive director serves as the agency spokesperson and media contact. In addition, the commissioners and other senior staff speak to civic and professional groups whenever they have an occasion. The Commission is involved in an annual educational seminar, an annual medical seminar, and has sponsored at least three educational programs for insurance carriers during the past year.

The Commission has identified the needs for an ombudsman section similar to that operated in other states. The request in the FY 1988-89 budget request is priority thirteen not because the Commission feels that it is not important but because there are serious deficiencies in other program areas that are critically compounding the operations of the Commission.

The Commission has only one compliance officer to serve the entire state and the more than 70,000 employers required to have workers' compensation insurance. That person's total efforts are devoted to identifying uninsured employers against whom someone has filed a claim. Posters are inspected in conjunction with other investigations, and the Commission does not have

additional staff to assign to this task. The second priority of the FY 1988-89 budget is for two additional compliance officers to work in this area.

Through the Commission's contact with claimants at viewings and hearings, claimants are given a personal explanation of the system and the rights and benefits available to them. In addition, the Commission has published an informative bulletin for claimants, and it is actively distributing those bulletins through organizations such as the Workers' Rights Project, personnel associations, professional groups, chambers of commerce, AFL-CIO and to individual workers who request information about the system.

Recommendations - page 68

48. The Workers' Compensation Commission does not have the staff nor the computer capacity to consistently monitor and enforce the timely payment requirements of the statute. Because of the increasing number of claims, any improvement in this area will take additional staff and increased capacity in our data processing ability.

50 and 51. The Commission recognizes that there are some legitimate reasons (claimant has not reached maximum medical improvement, attorneys scheduled before different commissioners, etc.) to postpone a hearing that are not listed in Regulation 67-31. The Commission will initiate a review of this specific regulation and will include an amended version in its package for promulgation under the Administrative Procedures Act.

Recommendation - page 74

54. The Commission recognizes that the administrative requirements for reporting claims must be balanced with the potential abuses caused by employers not reporting claims. All efforts will continue to be made to make the best use of administrative resources without jeopardizing or prejudicing the rights of injured workers to make claims for reported accidents.

Recommendations - page 76

57. In order to provide adequate protection to the employees of self-insureds and to provide the self-insured employer an opportunity to establish financial responsibility within existing market conditions and to his best economic benefit, the Workers' Compensation Commission believes that an individualized package of requirements is in the best interest of all concerned. The Commission will develop guidelines for monitoring the financial condition of self-insureds and will investigate other methods of determining financial ratios.

58. The Commission will ensure that all self-insureds submit audited financial statements annually. The Commission believes that recent staff changes in this area, along with the addition of a computer, will guarantee that all statements are received.

Recommendations - page 78

59 and 60. The Commission will completely review its procedures for qualifying self-insureds to include establishing guidelines for determining security deposits and other forms of reinsurance.

Recommendations - page 79

61, 62 and 63. The Commission has only one employee with which to manage the self-insurance program. To the extent possible, the Commission will conduct random audits of self-insureds. This particular area is growing rapidly each year, and one individual cannot properly qualify and

audit all the individual self-insureds and fund members during the course of a year. The Commission will give serious consideration to the recommendations of the Council in an effort to improve the management of this area.

Recommendations - pages 81

64 and 65. The Workers' Compensation Commission will review its procedures for assessing and collecting fines and penalties and will address the problems with consistency and enforcement that the Council has identified.

## PART II

## STATUTORY ISSUES

The issues identified in Part II of this review concern the level of benefits available to injured employees. The Commission believes that any adjustment to workers' compensation benefits is strictly a legislative prerogative. The Commission has pledged itself to monitor, regulate, enforce, and adjudicate the claims that come before the Commission according to the Workers' Compensation Act. The Commission will make its resources available to the General Assembly during the course of any study of the statutory issues, and the commissioners and the Commission staff will cooperate to the fullest extent possible in any discussion of the administrative ramifications resulting from any change to the existing legislation.

## PART III

## WORKERS' COMPENSATION COST FACTORS

By the very nature of its legislative mandate, the Legislative Audit Council has concentrated on what is wrong with the workers' compensation system and the management practices of the Workers' Compensation Commission. The specific findings in this report notwithstanding, there are many positive aspects of both the system and the Commission. While the law and the Commission's administration need to be improved, the observations and recommendations provided by the LAC in this section indicate that South Carolina's employees are receiving responsible benefits while the state's employers are paying workers' compensation premium rates which are below both the national and southeastern average. The LAC has also identified some hidden cost factors in the state's cost of workers' compensation premiums. Should the legislature pursue the issues identified by the LAC, the Commission will provide whatever support is requested from it.

# The South Carolina Second Injury Fund

KOGER CENTER
WINTHROP BUILDING, SUITE 119
220 EXECUTIVE CENTER DRIVE

DOUGLAS P. CROSSMAN
Director

Phone: 803-798-2722

Columbia, S.C. 29210

January 14, 1988

Mr. Stan H. Gooding
Certified Public Accountant
Legislative Audit Council
620 NCNB Tower
Columbia, SC 29201

Dear Stan:

I have reviewed the Audit Council's proposal concerning the Insolvency Fund and its administration. I am in complete agreement with the Council's recommendation. I feel that this would place no additional burden on the Second Injury Fund and would be of benefit to the State.

Very truly yours,

Douglas P. Crossman

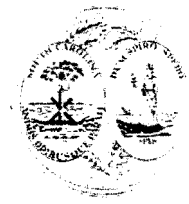
Douglas P. Crossman
Director

DPC/lm

State Workers' Compensation Fund

P.O. BOX 102100

Columbia, S.C. 29221-5000



Irvin D. Parker
Director
(803) 737-9450

January 18, 1988

Mr. George L. Schroeder
Director
Legislative Audit Council
620 NCNB Tower
Columbia, South Carolina 29201

RE: Administration of the Insolvency Fund

Dear Mr. Schroeder:

We agree with the finding that the administrative costs of the Insolvency Fund should be borne entirely by the carriers and self-insurers that sustain the Insolvency Fund.

There are two logical ways to do this: 1) The State Workers' Compensation Fund could charge administrative costs to the Insolvency Fund on a pro rata basis; 2) The Second Injury Fund which is sustained entirely by the carriers who should pay these costs, could administer the Insolvency Fund. Which solution is best depends upon which is more economical.

The State Workers' Compensation Fund is staffed and trained to receive, process, pay, monitor, terminate and litigate claims of individual workers. This, of course, requires processing weekly compensation checks, approval of medical treatment, approval and payment of medical and drug bills as submitted, referring workers to appropriate medical and vocational rehabilitation services, monitoring the healing process and employment situation and terminating compensation on a timely basis when maximum improvement is reached or the claimant returns to work. Such termination regularly requires a hearing before the Commission and, in appropriate cases, appeals to the courts. We have a legal staff skilled in such proceedings and issues.

If, as your report concludes, the Second Injury Fund is already similarly staffed and experienced in these particulars perhaps that agency would be the most logical administrator of the Insolvency Fund. If, however, that agency would have to hire new staff or retrain existing staff or otherwise redirect its

resources to handle this work, the small number of insolvency claims probably would not justify the investment.

Thank you for allowing us to comment on this matter.

With kindest regards,

Sincerely,

STATE WORKERS' COMPENSATION FUND

Irvin D. Parker
Director

IDP/jph